

HEALTH CARE REFORM

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED SECOND CONGRESS
FIRST SESSION

JULY 10, 1991—THE COSTS OF INACTION
JULY 29, 1991—PROPOSALS FOR EXPANDING AND
FINANCING COVERAGE
OCTOBER 31, 1991—CONTROLLING EXPENDITURES

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HEALTH CARE REFORM

The Costs of Inaction

WEDNESDAY, JULY 10, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:15 a.m., in room 2218, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

When I first came to Congress in 1975, the Nation spent \$132.8 billion on health care, or 8.3 percent of the gross national product. About 18 million Americans—roughly 10 percent of the population under age 65—were uninsured. Then, as now, there were serious concerns about the costs of public and private health benefit programs and about a large uninsured population. An effort was made to enact a national insurance bill.

President Nixon had introduced legislation proposing an employer mandate for workers and their families, public coverage for those outside the workforce, and improvements in Medicare. In early 1974, the Congress gave the Nixon plan a close look but decided not to act.

Seventeen years later, health care reform is once again the subject of serious debate here in the Congress. The Nation is now spending some \$676 billion on health care, or 12.4 percent of our gross national product, and over 33 million Americans—15 percent of the population under age 65—are uninsured. By the year 2000, health spending is projected to be more than 17 percent of the gross national product.

There is no dispute that growing numbers of uninsured Americans and unacceptable health cost increases require us to pursue fundamental reform of our health care system. Many businesses find their health benefit costs are equal to after-tax profits. Workers are experiencing higher out-of-pocket costs for care and in many cases losing coverage for their dependents. Moreover, the cost of health care is an increasing burden on the competitiveness of American goods and services in international markets.

In Congress, attention to these problems is accelerating. The Senate Majority Leader has introduced a comprehensive proposal and has indicated he intends to bring the measure to a vote in this

Congress. The House Democratic Leadership is coordinating the development of a proposal for consideration by the House after review by this and other committees of jurisdiction. Unfortunately, only the Bush administration, unlike the Nixon White House, seems uninterested, despite the President's State of the Union promise that, "Every American has a right to health care."

Today's hearing marks the first in a series to prepare the members of this subcommittee for consideration of health care reform legislation. Over the next few months, the subcommittee will be looking at different approaches to health care reform and their impact on the access and cost crises that confront our Nation. Today's hearing asks one simple question about health care reform: What happens if we do nothing?

Someone once said, "If it ain't broke, don't fix it." Well, America's health care system is broke. Millions of Americans do not have access to basic health care services, and millions more are just a paycheck or a serious illness away from losing their coverage. The cost of care for those who do have access is already too high and is growing at unsustainable rates.

Our witnesses this morning will tell us what will happen over the next 5 to 10 years if we listen to the Bush administration and do nothing. Will health care costs continue to rise and, if so, how rapidly? How will these cost trends affect large and small employers? Workers and their families? Those outside the workforce? Federal and State governments? Will coverage of basic care further decline? Will the number of uninsured increase, and, if so, by how much?

What are the implications of doing nothing for large and small employers? For our Nation's competitive position in a global economy? If we do nothing, can we realistically expect to achieve the objectives set forth in Healthy People 2000 for maternal and infant health, heart disease and stroke, cancer, diabetes, HIV infection, STD's, immunizations, and clinical preventive services?

Today's hearing will give us some answers to these questions, and we will then be able to start examining the various approaches to health care reform. That will be the task of subsequent hearings.

Before calling on our witnesses, I want to recognize Dr. Rowland for any opening comments he may wish to make.

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. Chairman, there are not many issues that concern the American people more than the problems that exist in our health care delivery system. This is certainly true for my own area of middle and south Georgia, and I believe it is also true for the rest of the country.

I recently sent out a newsletter that dealt entirely with health care, and the response that we had from that was extraordinary. It has generated far more letters and calls than any other newsletter that we have sent out during the 8½ years that I have been here in Congress. Many people related their own deeply troubling experiences; others offered suggestions about how the system could be improved; all of the letters and calls reflected the profound concern that people have about their access to care and the cost of that care.

At the appropriate time, Mr. Chairman, I want to share some of these letters with you and the other members of the subcommittee. Some of the ideas, I think, are worth considering. They tell the human side of the story that so often is told only in statistical terms.

The statistics are bad enough. My own State ranked sixth in the country in the number of uninsured citizens under 65 years of age. There are about one million Georgians without health insurance coverage, close to 20 percent of the population under 65. It is a tragic fact that rising costs have put health care out of the reach of a growing number of Georgians.

Mr. Chairman, I commend you for these hearings and look forward to working with you and other members of this subcommittee to address the problems in our health care delivery system that are causing so much distress in our country.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Rowland.

First of all, without objection, any opening statements that members of the subcommittee wish to have inserted in the record at this point will be made part of the record.

We are pleased to have for our first witness Robert D. Reischauer, director of the Congressional Budget Office.

We are looking forward to your testimony. Your prepared statement will be in the record in its entirety. We would like to ask, if you would, to limit the oral presentation to no more than 5 minutes.

STATEMENT OF ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. REISCHAUER. Thank you, Mr. Chairman and Mr. Rowland. I appreciate the opportunity to appear before the subcommittee to talk about the trends in the numbers of people in this country without health insurance and the escalating costs of health care. I will summarize my prepared statement.

Mr. WAXMAN. Mr. Reischauer, as I understand it, staff has discussed with you, and you were planning to take a little longer time on your presentation, so I did want to mention that fact and have you proceed as you see fit.

Mr. REISCHAUER. Thank you.

I will summarize my prepared statement and discuss these two issues in a summary fashion by referring to and describing the tables that are appended to the back of my prepared statement. They are also in a handout that you have before you that looks like this (indicating document). The people in the audience can look at the end of my prepared statement for these tables.

Discussions of the U.S. health care system often have a tendency to sound a little like a demolition derby, so let me start by noting that our system has a number of strengths that, I think, all Americans value highly. Among these, of course, are the very high quality of care that is received by most Americans, the rapid dissemination of new technologies that exist in our system, the access that we have that doesn't involve long waiting periods, and the wide

range of choice that most Americans have with respect to providers and type of insurance coverage.

However, we should note that most of these benefits are enjoyed by those with insurance, but, as you can see from table A-1, a substantial number of Americans lack health insurance. To be specific, some 15.3 percent of the population under 65—or about 33 million people—were without health insurance in March 1990.

You note that I said of the population under 65, and this, of course, reflects the great success we have had with the Medicare program; slightly over 99 percent of the aged population is covered by health insurance. The bad news, of course, is that we have these 33 million people without health insurance; the good news is that 85 percent of those under 65 have some form of coverage.

About 70 percent of the under 65 population had employment-based group health insurance in 1990 either through their own employer or through the employer of a spouse or a parent. Another 8.5 percent of them were insured through a public program—Medicare, Medicaid, VA, and so on—and then there was another 7 percent that were insured through individual insurance policies that were really unrelated to employment.

The second table in the handout, table A-2, provides a detailed look at the uninsured. It shows first of all that three-fifths—a little over 60 percent—of the uninsured were low income; they were either poor or they had incomes below 200 percent of the poverty level.

Another interesting fact shown in this table is that children are not disproportionately uninsured. Slightly over 13 percent of children lack health insurance, whereas a little over 15 percent of the under 65 population as a whole lack insurance. Minority populations, blacks in particular, are disproportionately uninsured.

The widespread reliance on employer-based insurance is explained in part by the practice in this country of excluding employer-paid fringe benefits from taxable income, which means that the average worker has to give up only 67 cents in after-tax income to obtain a dollar's worth of health insurance coverage. In a sense, we provide through the tax system, group health insurance by employers at fire sale prices to the employees.

This exclusion of employer-paid health insurance premiums from taxable incomes represents about a \$48 billion Federal subsidy to group health insurance, and since State and local governments have similar tax preferences in their tax codes you add another \$8 to \$10 billion to that. So about \$56 to \$58 billion worth of tax subsidy is being provided for employment-based health insurance.

Despite these subsidies, however, not all employers provide health insurance coverage. As you can see from table A-3, about 80 percent of the uninsured have some relationship to the workforce. They are either workers themselves or they are in families where at least one person is employed. Only a fifth—about 20 percent—of the uninsured live in families that have no connection to the employed labor force.

The next table, A-5, shows that a major factor affecting the availability of employment-based group insurance is the size of the firm. Only 39 percent of the firms with fewer than 25 workers offer insurance, but virtually all of the firms that employ 100 or more

workers do so. One reason for this discrepancy is that the administrative costs of group health insurance fall rather substantially with the size of the group, and one finds that firms with fewer than 50 employees face administrative costs of at least 25 percent of the benefits, and firms that have an employment or group base of 500 or more workers have administrative costs that are roughly half that amount, 12 percent of the benefits or less.

Over the past decade, the prevalence of employment-based insurance has declined. For fulltime workers, the coverage has fallen from about 77 percent in 1980 to about 74 percent in 1987. We don't have any comparable data for the last few years, but the non-comparable data suggests that probably the prevalence of employment-based health insurance for fulltime workers has fallen another couple of percentage points since 1987.

Low- and moderate-wage workers, who always have had lower rates of coverage, have borne the brunt of this decline. In other words, they have seen their coverage decline more precipitously than upper-income workers have. With health care costs rising much more rapidly than wages, this gradual erosion in health insurance coverage that we have experienced over the last decade is likely to continue in the future if nothing is done, which was the question posed by the chairman.

As you are well aware, the consequences of being uninsured in America can be extremely severe. The uninsured use fewer services than the insured. In the hospital, they are less likely to receive expensive treatments, and they are also significantly more likely to die, even adjusting for the differences in health status when they enter the hospital.

There are a number of ways that coverage could be expanded that have been widely discussed. These include establishing tax subsidies to encourage uninsured individuals to purchase insurance, adopting regulatory changes to increase the availability of health insurance, especially for small groups and for high-risk individuals, mandating that employers provide insurance for all their workers, expanding the Medicaid program to cover a higher fraction of the low-income population, and establishing a universal health care plan of some sort. CBO has analyzed several of these options at the request of the subcommittee, and we are releasing that report today.

All of these options that I just listed, of course, would raise national health spending. This brings us to the second topic that I would like to cover, trends in health care spending over the past few decades. In 1989, the last year for which we have comprehensive numbers, the United States spent about \$2,400 per person on health care. The annual rate of increase over the 1980's decade per capita in real terms was 4.4 percent. That is a pretty healthy rate of increase.

As you can see from figure A-1 on the next page, the United States spends considerably more of its resources on health than do other developed countries. Focusing just on the English speaking world, in 1989 we spent 11.8 percent of our GDP on health compared with 8.7 percent in Canada and 5.8 percent in the United Kingdom.

Over the past few decades, a marked change has occurred in the distribution of health care expenditures in the United States. This is brought out in figure A-2, which shows that the out-of-pocket share has declined from about 40 percent in 1970 to a bit over 23 percent in 1989, while the share picked up by private insurance has risen from 23 percent to about 33 percent, and the government's share—and this includes Federal, State, and local—has increased from about 35 percent to 41 percent over this period.

It is interesting to note that between 1980 and 1989 there was virtually no change in the share paid for by government. If we lump together Federal, State, and local, the government share remains about the same.

While out-of-pocket spending has declined as a share of total health expenditures, it has remained a fairly stable fraction of after-tax income, just below 5 percent over the last few decades, as is brought out by figure A-3. This has not been the case for Medicare beneficiaries, who not only spend a much higher fraction of their after-tax resources on health care but have seen that fraction rise fairly steadily over the 1972 to 1989 period.

Hospital spending in real terms has grown about 51 percent over the 1980 to 1989 period despite all of our efforts to control such spending through managed care and through Medicare's prospective payment system. While admissions declined some 13 percent over this decade, real spending per admission rose about 64 percent.

As figure A-4 shows, higher spending for hospital care went hand in hand with higher hospital margins on total revenues over much of this period. There was a slight decline over the last half of the 1980's, but hospital margins remain significantly above what they were in the late 1960's and the first half of the 1970's.

Spending for physicians' services increased even more rapidly than spending for hospitals over this most recent decade. In fact, in real per capita terms, such spending increased by 71 percent. Not surprisingly, physicians' incomes after expenses have also risen at a pretty good clip during the 1980's. In real terms, they rose 20 percent between 1981 and 1987.

But to be fair, I think I would have to note that lawyers and other professionals did pretty well during the 1980's as well. Physicians aren't the only group of highly trained Americans who saw their real incomes rise at a good pace. But it is clear that U.S. physicians earned considerably more than their counterparts in other countries in the world, in both absolute and relative terms.

The relative picture is brought out in figure A-5, which shows that U.S. physicians earned about five times the average compensation of all workers in 1986, which is the last year for which we have data, while physicians in other countries earned generally between three and four times the average worker's compensation.

The rapid growth of national health spending has had a significant impact on the Federal budget, as you can see from the middle panel of table A-5. In 1970, spending on health constituted 7.1 percent of the Federal budget. By 1990, that share had grown to 13.4 percent, and under CBO's baseline projections we expect that share will rise to 19.5 percent by 1996.

The fastest growing component of Federal health expenditures is the Medicaid program. Real Federal Medicaid expenditures will rise, under our projections, at a rate of about 10.5 percent a year between 1990 and 1996, and Medicaid's share of the Federal health budget will increase from 24.5 percent in 1990 to nearly 30 percent in 1996. The share for Medicare will decline a bit.

The recent rapid rise in Medicaid expenditures is attributable to the options and mandates that have been enacted to expand eligibility, also to the initiatives that States have taken to enroll more of the eligible population, as well as to the economic slowdown, although we probably haven't seen the full impact of the latter on spending at this point.

Table A-6 provides some information on recent increases in payments and recipients broken down by eligibility category. The next table, A-7, shows that Medicaid expenditures are still dominated by spending for the elderly and the disabled in spite of the recent rapid growth in expenditures for pregnant women, infants, and children.

In 1989, almost 70 percent of Medicaid's recipients were adults and children in low-income families, but they accounted for only a bit over a quarter of all of Medicaid's expenditures; the rest was for the aged, disabled, and blind.

Figure A-6, on the next page, shows what has been happening in the Medicare program and what we can gain from that is a picture of considerable change. During the 1970's and the first half of the 1980's, Medicare spending both in the aggregate and on a per capita or per enrollee basis was growing at a considerably faster clip than national health spending on a per capital or aggregate basis.

However, this situation reversed itself in the last half of the 1980's. On a per enrollee basis, Medicare spending grew by 3.2 percent a year, whereas national spending per capita grew at 4.6 percent a year. This is from the bottom panel of figure A-6. I note that these expenditures are in real terms. We have taken out general inflation already. So it is a healthy pace of increase even with respect to Medicare.

The next figure, A-7, the bottom two panels indicate that most of the decline in the growth in the last half of the 1980's in Medicare stems from a substantial drop in the rate of increase in Medicare spending for hospital services per enrollee, which increased at only half a percent a year.

Physicians' services, as you can see, perked along at pretty much the same rate as physicians' services per capita in the aggregate numbers in the overall population, but the hospital services declined to only half a percent per year per Medicare enrollee in real terms, whereas in the national picture it remained at 3.6 percent.

Let me conclude this by trying to tie together the two issues that I have covered with a single observation. That observation is that it will be difficult to expand the coverage to provide protection to more of the uninsured as long as health spending is growing at 10 to 12 percent a year. The American people will want some kind of assurance that we have also dealt effectively with measures to control costs.

Unfortunately, our varied efforts along these lines, which I believe are going to be discussed by some of the other witnesses at these hearings, have been noticeably ineffective. In a sense, even a worse message is, should we be able to adopt effective methods of controlling costs, it is almost certain that we would have to sacrifice to some degree the beneficial and desirable elements of the current health care system which I discussed in my opening comments.

That concludes the discussion. I will be glad to answer any questions.

[Testimony resumes on p. 43.]

[The prepared statement of Mr. Reischauer follows:]

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss trends in the number of people without insurance and the costs of health care. In addition, I will describe the effectiveness of various strategies for controlling health care costs in the United States.

OVERVIEW OF THE HEALTH CARE SYSTEM

The U.S. health care system has many strengths. Because of the resources devoted to research and because our current financing system encourages the rapid dissemination of new technologies, we are able to provide the highest quality care in the world. The substantial majority of the population--those with health insurance--have access to care without waiting and there are few limits on our choices of providers, types of health coverage, and alternatives for treatment.

Yet, over the past two decades, criticisms of the health care system have grown: substantial numbers of people remain without health insurance, either private or public, and health care spending per person is much higher than in other countries and is rising faster than the gross national product. Since policies to address one of these problems may cause a worsening of the other one, we may anticipate further deterioration of insurance coverage or continued rapid increases in spending for health care.

TRENDS IN INSURANCE COVERAGE

In March 1990, 70 percent of the nonaged population had health insurance through an employment-based group, either because their own employer offered it or because they were insured as a dependent of a worker whose employer offered group coverage (see Appendix Table 1). Another 8.5 percent of the nonaged population were insured through a public program--Medicaid (6.7 percent), Medicare (1.4 percent), or the VA (0.4 percent). Nearly 7 percent were insured through individual insurance policies unrelated to employment. The remaining 15.3 percent of the nonaged population--about 33 million people--were without insurance coverage. (Because more than 99 percent of the elderly participate in Medicare, they make up a negligible proportion of the uninsured.)

Three-fifths of the uninsured were poor or near-poor--those with incomes less than 200 percent of poverty (see Appendix Table 2). Children were somewhat less likely than others to be uninsured--13.3 percent of children were uninsured versus 15.3 percent of the nonaged population overall. Moreover, although white people account for 78 percent of the uninsured, nonwhite people are much more likely to lack coverage.

Employment-Based Insurance

Excluding employer-paid fringe benefits from the taxable income of the employee encourages the substantial reliance on employment-based group insurance to provide financial protection against health care costs. For example, an employee with a marginal federal income tax rate of 15 percent, a federal payroll tax rate of nearly 8 percent, and a state income tax rate of 5 percent, is able to obtain \$1 worth of health insurance coverage paid by an employer at a marginal cost to the employee that is equivalent to about 67 cents of after-tax income.

Excluding the employer-paid share of health insurance from taxable income provides a federal subsidy for group insurance of about \$48 billion in 1991. Estimates show that similar provisions in state income tax codes provide another \$8 billion to \$10 billion in subsidy annually. Despite these subsidies, not all employers offer health insurance. About 80 percent of the uninsured are in the workforce or are in a family where at least one person is employed. Only 19.4 percent of the uninsured have no family connection to the employed labor force (see Appendix Table 3).

A major factor affecting the availability of employment-based group insurance is the size of the employing firm. Only 39 percent of firms with

fewer than 25 workers offer insurance, but virtually all firms with 100 or more workers do so (see Appendix Table 4). Moreover, regardless of their size, firms that do not offer health insurance have substantially higher proportions of low-income workers than firms that do offer health insurance. In addition, the decline in the proportion of full-time workers with employment-based health insurance--from 77.2 percent in 1982 to 73.8 percent in 1987--appears to have primarily affected low- and moderate-wage workers. With health care costs rising much more rapidly than wages, this gradual erosion of health insurance coverage is likely to continue. It may be offset in part, however, by Medicaid eligibility continuing to expand, which will occur through the beginning of the next century.

One reason that small firms are less likely to offer insurance may be that the administrative costs associated with small groups are very high. Firms with fewer than 50 employees face administrative costs of at least 25 percent of the cost of benefits, compared with 12 percent or less for groups with 500 or more employees.

Consequences and Possible Responses

People without insurance use fewer services than do the insured and, although some of the forgone services may be of limited value, important ones are apparently also not obtained. A recent study of five medical procedures that are expensive and have a substantial discretionary element found that, among the hospitalized, those without insurance were 29 percent to 75 percent less likely to undergo the procedures, even though the uninsured were sicker when they were admitted. Uninsured patients were also significantly more likely to die in the hospital, even after adjusting for factors such as their poorer health. Clearly, the consequences of being uninsured can be severe, both for the individual and for society.

In response to concerns about the problems the uninsured face in obtaining access to health care, a number of options to expand coverage to more people have been considered. They include:

- o Establishing new tax subsidies that would provide incentives for individuals to purchase insurance;
- o Changing federal regulations to increase the availability of health insurance for small groups and for high-risk individuals;

- o Mandating that employers provide health insurance to their workers;
- o Expanding the Medicaid program to cover all people under the federal poverty level and to permit other low-income people to "buy-in" to Medicaid; and
- o Establishing a universal health plan that would cover everyone under one program.

CBO is releasing today a study titled Options to Expand Health Insurance Coverage, which was prepared at the request of this Subcommittee, that examines several of these options.

Because all of these proposals would raise national health spending and the federal budget deficit, enacting any of them at a time when spending for health is growing at an annual rate of 10 percent to 12 percent a year would be difficult, unless policies that would effectively control costs were also put in place. To date, however, our varied efforts to contain health care costs have been notably ineffective.

TRENDS IN SPENDING FOR HEALTH CARE

In 1989, the United States spent \$604 billion on health care--or about \$2,400 per person. The annual rate of increase in real per capita spending between 1980 and 1989 was 4.4 percent. Even if we assume that the annual rate of increase will be considerably lower in the 1990s--for example, 3.3 percent--we would spend almost \$3,400 per person (in 1989 dollars) on health care in the year 2000. Moreover, the United States already spends much more on health than do other developed countries--11.8 percent of gross domestic product in 1989, compared with 8.7 percent in Canada, 8.2 percent in the former West Germany, 6.7 percent in Japan, and 5.8 percent in the United Kingdom (see Appendix Figure 1).

As health spending has risen, its distribution by payer has also changed. The share of personal health spending that householders pay out-of-pocket declined from 39.5 percent to 23.5 percent between 1970 and 1989. In contrast, private insurance payers and governments have taken on an increasing share. Private insurance accounted for 23.4 percent of health spending in 1970 and 32.6 percent in 1989, while federal, state, and local governments paid for 34.6 percent in 1970, before Medicare and Medicaid were enacted, but 40.6 percent in 1989 (see Appendix Figure 2).

Impact on Consumers

Even though out-of-pocket spending has declined as a share of total health expenditures, it was relatively stable as a percentage of after-tax income--just below 5 percent over the past two decades (see Appendix Figure 3). Medicare beneficiaries, however, not only spend a much higher proportion of their income on health care than the average household, but they have also seen this proportion rise fairly steadily--from 7.8 percent in 1972 to 1973 to 11.5 percent in 1989.

In fact, a small fraction of the population each year accounts for an exceptionally high proportion of total spending for health care. In 1980, the 50 percent of the population with the lowest health bills accounted for only 2 percent of total health spending, while the 10 percent with the highest expenditures accounted for 75 percent. This pattern holds for the population under age 65, not just for the aged population.

Impact on Providers

During the past decade, much of the effort to control health care costs has focused on hospital spending--both through managed care that attempts to

control hospital admissions and lengths of stay and through Medicare's Prospective Payment System. Nevertheless, during that period, hospital spending continued to rise. For example, in 1980, we spent \$154 billion (in 1989 dollars) on hospital care, compared with \$233 billion in 1989. This growth was the result of a striking 64 percent increase in real spending per admission between 1980 and 1989, which more than offset the 13 percent drop in admissions.

Higher spending for hospital care went hand in hand with higher hospital margins on total revenues over much of this period. Although hospital margins declined from 5.9 percent to 4.8 percent between 1985 and 1990, these margins are still substantially higher than those present between 1965 and 1975 (see Appendix Figure 4).

Spending for physicians' services increased even more rapidly than spending for hospital services over the past decade. In 1980, we spent \$268 per person (in 1989 dollars) on physicians' services; by 1989, we were spending \$458 per person--a 70 percent increase in real spending per person over a nine-year period.

Physicians' incomes, after expenses, also rose during the 1980s--nearly 20 percent in real terms between 1981 and 1987. U.S. physicians earn

considerably more than their colleagues in other countries, both in absolute and in relative terms--around 50 percent more than physicians in Canada and West Germany, and nearly three times as much as physicians in the United Kingdom and Japan. While U.S. physicians earned five times the average compensation of all U.S. workers in 1986, physicians in other countries earned only two to four times the average worker's compensation (see Appendix Figure 5).

Impact on the Federal Budget

The rapid growth of national spending for health care, overall and per capita, also has significant implications for the federal budget. In 1970, spending on health constituted 7.1 percent of the federal budget. By 1990, that share had grown to 13.4 percent. Even more disturbing, CBO is projecting that health care will account for 19.5 percent of federal spending by 1996 (see Appendix Table 5).

Medicaid. The fastest growing component of federal health expenditures is the Medicaid program. After taking general inflation into account, we project that real federal Medicaid expenditures will rise at an average annual rate of 10.5 percent between 1990 and 1996. The corresponding growth rates

projected for Medicare and all other federal health expenditures are 6.1 percent and 4.4 percent, respectively. Consequently, Medicaid, which accounted for 24.5 percent of federal health expenditures in 1990, will account for nearly 30 percent of federal health expenditures by 1996.

Rising Medicaid expenditures also affect state budgets. According to the National Association of State Budget Officers, Medicaid expenditures increased on average from 10.2 percent of state budgets in 1987 to 12 percent in 1990.

Several factors may have contributed to the recent rapid rise in Medicaid expenditures, including the options and mandates to expand eligibility for pregnant women, infants, children, the elderly, and the disabled, and state initiatives to enroll more eligible people. The recession could also lead to increases in the eligible population, although data are not yet available to assess its impact.

Estimating the budgetary impact of changes in eligibility for different groups is difficult because states have varied widely in the timing, nature, and magnitude of their responses. Nonetheless, Medicaid expenditures rose significantly for adults and children in low-income families in 1989, only a portion of which was because of the larger numbers of program participants

(see Appendix Table 6). After taking general inflation into account, expenditures for adults and children in low-income families grew by 12 percent and 12.6 percent, respectively, but the actual numbers of recipients in both categories rose by 3.9 percent and 2.8 percent. Thus, higher expenditures per person accounted for the greater part of the increase in expenditures. Preliminary data for 1990 suggest that this pattern is continuing.

In spite of the recent rapid growth in expenditures for pregnant women, infants, and children, total Medicaid expenditures are still dominated by spending for the elderly and the disabled (see Appendix Table 7). In 1989, almost 70 percent of Medicaid recipients were adults and children in low-income families. Yet, they accounted for only about one-quarter of Medicaid payments, if only because the average Medicaid payment per person in low-income families was less than \$1,000 compared with almost \$6,000 per person for the elderly and the disabled. This difference largely reflects the extensive use of long-term care services by the elderly and the disabled. In 1989, for example, approximately 40 percent of all payments for Medicaid-covered services went to nursing homes.

Medicare. The annual rate of real growth in Medicare spending per enrollee was also substantially higher than growth rates in health spending per person in the nation throughout the 1970s and in the first half of the 1980s. But

Medicare's real growth in spending per enrollee moderated during the last half of the 1980s to 3.2 percent--a figure considerably less than the 4.6 percent the nation experienced (see Appendix Figure 6).

Most of the decline in growth in the last half of the 1980s stemmed from a substantial drop in the rate of increase in Medicare's spending for hospital services. While the real rate of growth in physician spending also declined somewhat, it continued at a 7.2 percent annual rate per enrollee during the 1985-89 period compared with 0.5 percent for hospital spending (see Appendix Figure 7).

The average annual real rate of growth of per capita spending for hospital care in the nation, however, was essentially stable over the 1980s, even though the rate of growth in Medicare's spending dropped substantially. This pattern illustrates a major factor in our inability to gain better control over health spending. In our multiple-payer system, successful efforts by one payer to reduce the growth in costs appear to be offset by more rapid increases in costs for other payers.

EVIDENCE ON COST CONTROL POLICIES

A number of strategies might be used to control health care costs, including:

- o Greater cost-sharing by consumers;
- o Managed care and other forms of controls on use;
- o Price controls;
- o Increased competition among providers and insurers; and
- o Regulatory policies, such as hospital rate-setting and certificate-of-need programs.

Cost Sharing

Policymakers have frequently discussed--though not expanded--cost-sharing as a means to increase control over health care costs. In fact, the proportion of expenditures on personal health that consumers paid out-of-pocket declined over the past decade, thereby actually contributing to the increase in health

spending. Even so, the United States remains significantly different from most other countries. For example, out-of-pocket costs were 7 percent in the former West Germany in 1985 and 3 percent in the United Kingdom in 1987. Evidence from studies of the effect of cost sharing on spending for health services does suggest that, if out-of-pocket costs were raised, use of services and total spending on health would decline. Such a reduction in spending would probably have a greater impact on low-income people than on others.

Managed Care

Managed care attempts to reduce inappropriate and unnecessary care by reviewing treatment decisions for specific individuals and, in some cases, limiting the patient's choice of providers. During the 1980s, the proportion of the population in managed care grew dramatically. In 1988, 48 percent of those with traditional insurance had some degree of managed care as part of their insurance package, 35 million were in health maintenance organizations (HMOs), and 18 million were in preferred provider organizations.

As for the impact of managed care, evidence indicates that only staff and group model HMOs--where the doctors are part of the HMO and have no independent practice--are clearly effective in reducing use and costs. Most

people are in much more loosely structured managed care arrangements, which have not consistently had a significant effect on spending. In addition, although the health care of nearly half the privately insured population is now subject to some type of review, its expansion appears to have had little or no effect on the overall level of spending on health. Furthermore, the administrative costs of monitoring individual patients and decisions about treatment can be high. Other countries do not monitor individual patients and procedures, but instead monitor and review providers, using data systems that include all patients. This process makes it possible to identify physicians who routinely deviate from standard practices.

Price Controls

Price controls are another method for controlling health costs. They have been used over the past decade, particularly by Medicare and Medicaid. When price controls are imposed, however, the volume of services rises. Controls may also adversely affect access to care if they are imposed for only one group, while providers can obtain higher prices for serving other groups. If price controls were applied uniformly to the whole health care system, they would have greater potential to control health care costs, although responses

in volume would still occur unless uniform monitoring of providers was also instituted.

Another approach to controlling prices is the all-payer hospital rate-setting strategy that has been tried for various periods in Maryland, Massachusetts, New York, and New Jersey. These states set the payment levels that hospitals received for providing services and required that all payers in the state--both private and public--use those rates. Studies of all-payer systems have shown that they generated a significant one-time drop in hospital spending of between 2 percent and 13 percent and also lowered the rates of growth in spending.

Competition

Another strategy for controlling health care costs that has been widely advocated is increased competition. Competition did increase among insurers and providers during the 1980s, but costs have not been reduced. Because consumers directly pay only a fraction of the full cost of their health insurance premiums and of the health services they use, most competition is apparently on the basis of generosity of benefits, amenities, and quality rather than on

price. Increased competition appears to have made consumers better off by giving them more choices, but it has had little effect on spending.

Regulatory Policies

A substantial amount of the growth in spending for health care--as much as 10 percent to 15 percent--appears to be associated with new technologies. Indeed, some have suggested that, if health care costs were to be controlled, it would be essential to limit the growth of technology. The health planning and certificate-of-need programs that the federal government required of the states in the late 1970s and 1980s, however, were ineffective in controlling growth in capital and new technologies, perhaps because they were applied in a nonsystematic way in most states. Other countries, however, do impose limits on capital and new technologies that seem to be effective--Canada, for example, had only 1 piece of magnetic resonance imaging (MRI) equipment for every 2 million people in 1989, compared with 7.4 for every 2 million people in the United States in 1987.

Finally, imposing limits on expenditures is a strategy that has been used in other countries and by Medicare for spending on physicians' services. Limits could be established in several ways:

- o Global budgeting for hospitals would set hospital budgets prospectively, so hospitals would not gain from admitting more people or from doing more than necessary;
- o Targets for spending on physicians' services would set penalties for exceeding targets, usually in the form of lower fees in the future; and
- o Expenditure caps would place absolute limits on spending.

All of these strategies could control spending, but their effectiveness would depend on how the limits were set and how stringently they were enforced.

CONCLUSION

Controlling costs in the United States is more difficult than in other countries that have coordinated health care policies or centralized health care systems. But one could achieve greater control over costs through a combined strategy that might include: eliminating first-dollar insurance coverage; monitoring medical care at the provider level; setting uniform payment levels for providers; controlling the growth of capital and technology, with goals set at

a national or regional level; and establishing effective national and regional expenditure limits.

Without significant changes, we are unlikely to achieve greater control over health care spending than we did in the 1980s, when real spending per person increased at an annual rate of 4.4 percent. Also, without cost containment, it will be more difficult to address the other major failure of our health care system--the large and growing number of people in the United States without health insurance coverage.

But to control costs we would have to make concessions regarding some elements of our present system that many perceive as desirable. Such concessions are likely to have adverse impacts on research and development, access to new technologies and treatments, and the freedom to choose insurance coverage, providers, and alternative treatments. Whether these trade-offs are desirable would depend on the priority the nation places on controlling costs as against maintaining these other characteristics of our current health care system.

TABLE A-1. HEALTH INSURANCE COVERAGE OF THE NONAGED POPULATION, BY SOURCE OF COVERAGE, 1990

Insurance Status and Source of Coverage	Number of of People (Millions)	Percentage of Nonaged Population
Total	216.7	100.0
Insurance Status		
Insured	183.6	84.7
Not insured	33.1	15.3
Source of Insurance Coverage ^a		
Employment-based	150.6	69.5
Other private	14.6	6.7
Public	18.4	8.5
Medicaid	14.6	6.7
Medicare	3.0	1.4
Veterans Affairs	0.8	0.4

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

a. "Source of Insurance Coverage" refers to the individual's primary insurance coverage when there are multiple sources of insurance coverage.

TABLE A-2. CHARACTERISTICS OF THE NONAGED UNINSURED POPULATION, MARCH 1990

Characteristics	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total Uninsured	33.1	100.0	15.3
Age and Sex			
Children under age 18	8.5	25.7	13.3
Young adults, ages 18 to 24	6.4	19.2	25.1
Adults, 25 to 54	15.7	47.0	14.9
Adults, 55 to 64	2.5	7.4	11.6
Income Level			
Below the poverty level	9.5	28.8	33.4
100 percent to 199 percent of poverty	10.5	31.8	28.5
200 percent of poverty and above	13.0	39.3	8.6
Race			
White	25.6	77.5	14.2
Black	5.8	17.5	20.7
Other	1.7	5.0	20.1

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

NOTE: Details may not add to totals because of rounding.

TABLE A-3. WORK FORCE CONNECTIONS OF THE NONAGED UNINSURED, MARCH 1990

Relationship to Work Force	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total			
Total Uninsured	33.1	100.0	100.0
Work Force Connection			
Employed	16.1	48.7	14.2
Dependent of employed person	10.6	31.9	14.4
Unemployed or not in labor force	6.4	19.4	21.6
Employment Level			
Full-time workers	13.4	40.4	12.6
Dependents of full-time workers	9.0	27.2	13.3
Part-time workers	2.7	8.2	34.2
Dependents of part-time workers	1.6	4.7	28.7
None	6.4	19.4	21.6

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

NOTES: Workers include anyone reporting that they were employed during the survey week, including those not at work.

The allocation among workers, dependents of workers, and those with no connection to the work force is based on the status of the individual. However, for those with a work force connection, the connection is classified as full time if anyone in the family works full time.

Full-time work is defined as 35 hours or more per week.

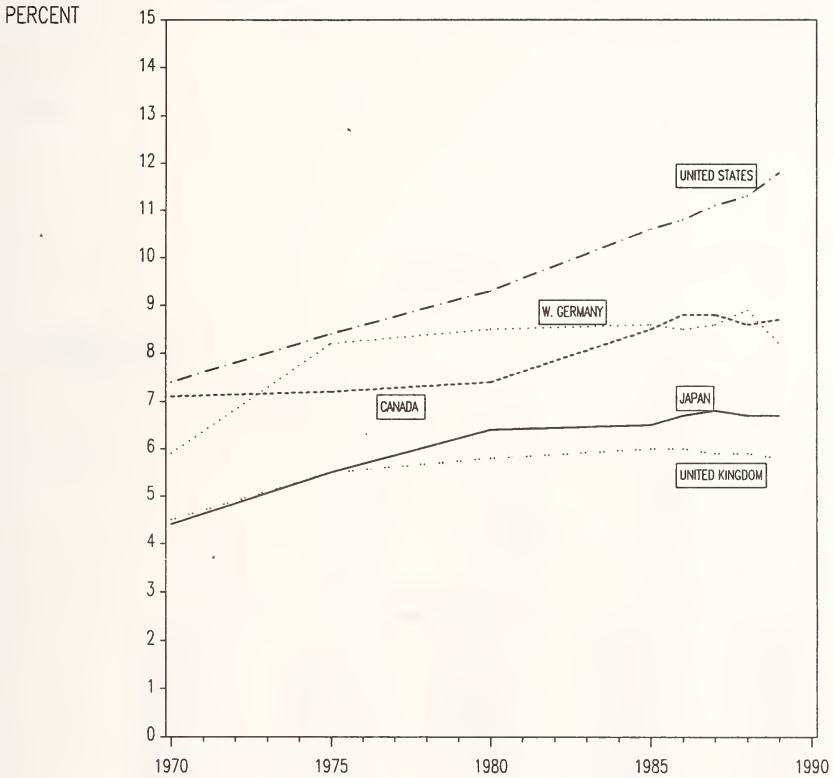
TABLE A-4. AVAILABILITY OF EMPLOYMENT-BASED INSURANCE PLANS, BY FIRM SIZE, 1989

Size of Firm (Number of employees)	Percentage of Firms Offering Insurance	Percentage of Employees in Firms Offering Insurance
Under 25	39	55
Under 10	33	42
10-24	72	70
25-99	94	94
100-499	99	97
500-999	100	100
1,000 and Over	100	100
Total	43	77

SOURCE: Congressional Budget Office from the 1989 Employer Survey by Health Insurance Association of America.

FIGURE A-1.

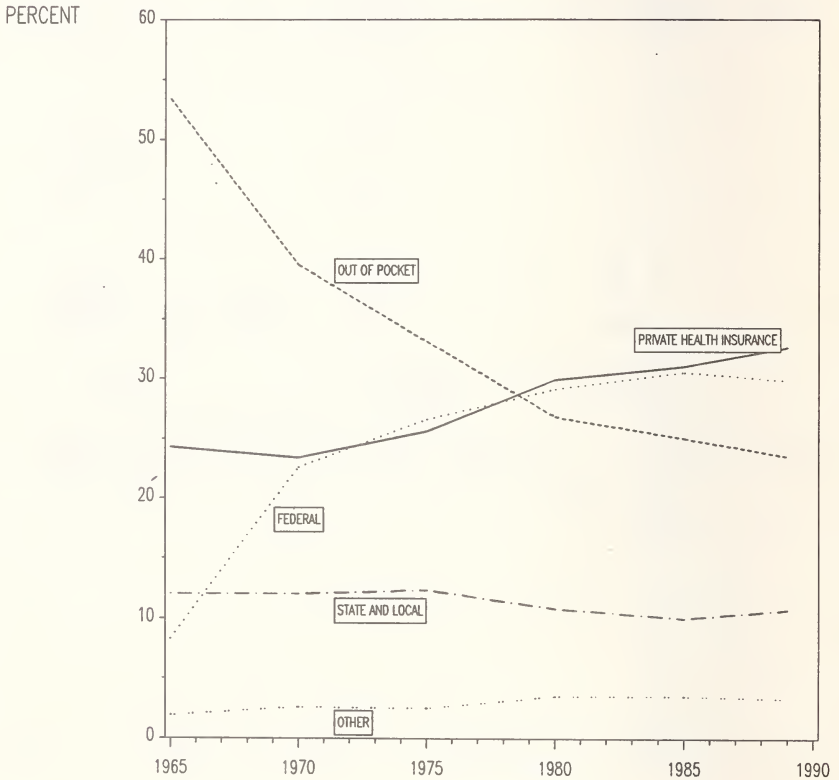
HEALTH EXPENDITURES AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT, IN THE UNITED STATES AND SELECTED COUNTRIES, 1970-1989



SOURCE: Congressional Budget Office calculations based on data from G. Schieber and J.-P. Poullier "International Health Spending: Issues and Trends", *Health Affairs*, Spring 1991.

NOTE: Gross domestic product (GDP) is equal to gross national product less net property income from abroad. Use of GDP for international comparisons of health spending eliminates variations arising from differences in the role of foreign transactions in different economies.

FIGURE A-2.
DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES BY SOURCE OF PAYMENT,
1965-1989



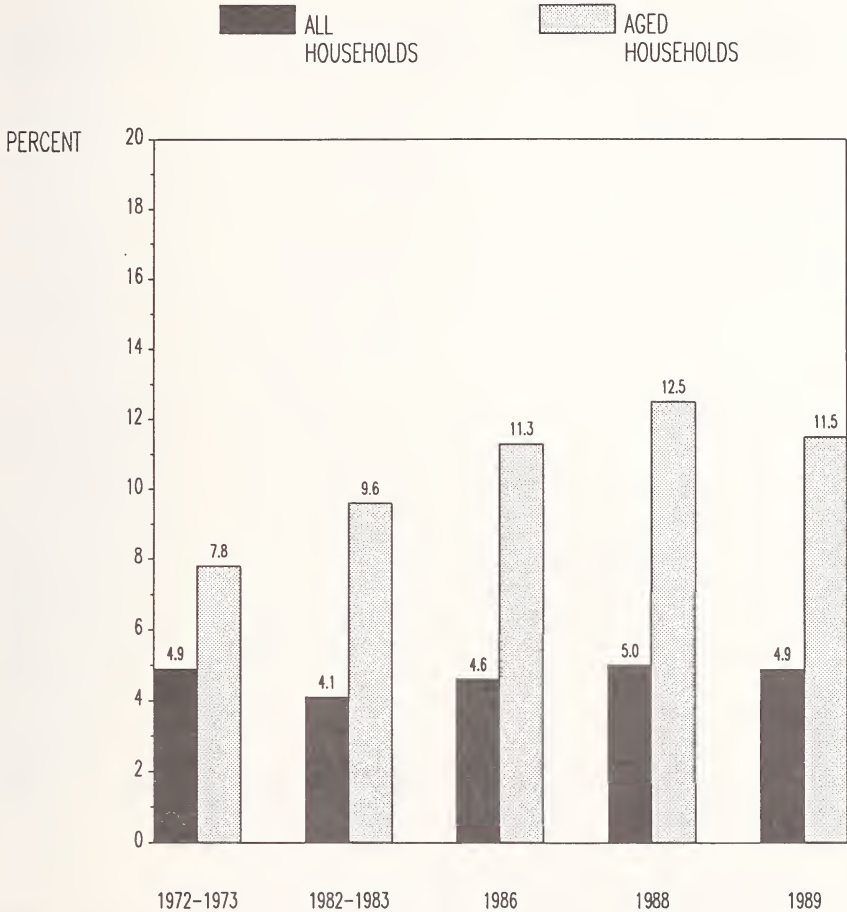
SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTES: Personal health care expenditures are equal to national health expenditures less spending for research, construction, and administrative costs.

The "other" category includes philanthropy and industrial in-plant spending for health.

FIGURE A-3.

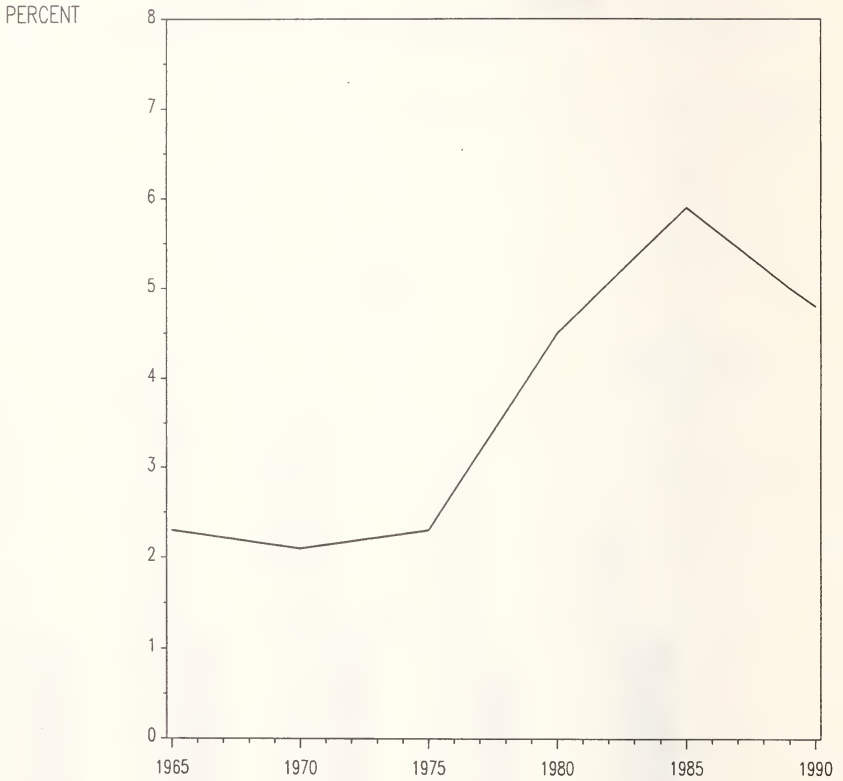
DIRECT OUT-OF-POCKET SPENDING FOR HEALTH AS A PERCENTAGE OF AFTER-TAX INCOME



SOURCE: Congressional Budget Office calculations, using data from the Consumer Expenditure Survey of the Bureau of Labor Statistics.

NOTE: Data are tabulated by age of surveyed person. Aged households are those in which the surveyed person is age 65 or over. Such households may include some individuals under age 65. The decline in direct out-of-pocket spending as a share of after-tax income for aged households between 1988 and 1989 may be due, in part, to the Medicare Catastrophic Coverage Act of 1988 which was partially in place in 1989, but repealed subsequently.

FIGURE A-4.
HOSPITAL MARGINS BASED ON TOTAL REVENUES, 1965-1990

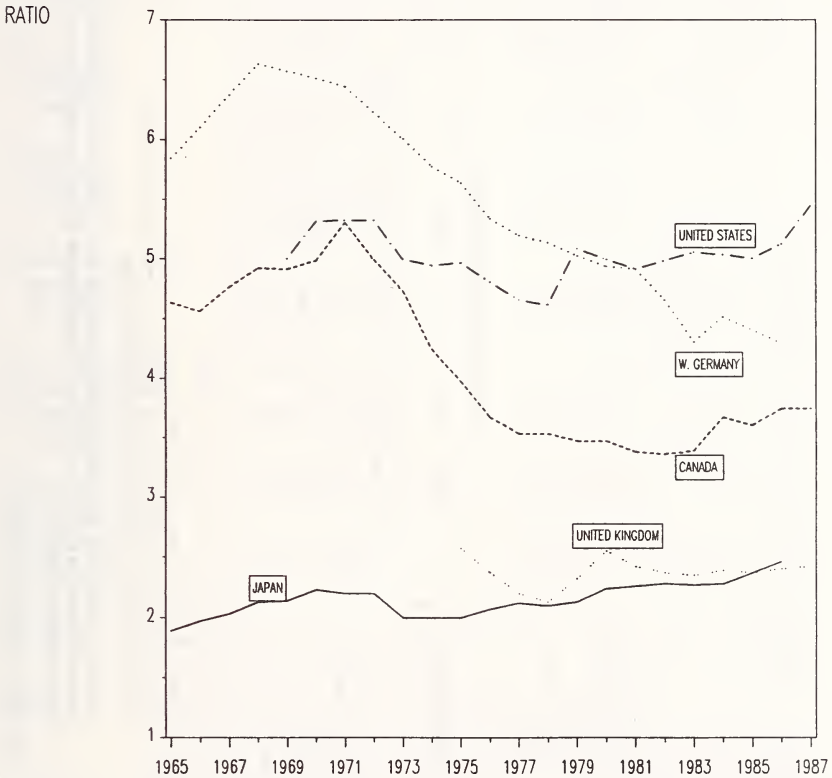


SOURCE: Congressional Budget Office calculations based on data from the American Hospital Association, National Hospital Panel Surveys, 1965-1990.

NOTE: The total margin is defined as the ratio of aggregate total revenues minus aggregate total costs to aggregate total revenues.

FIGURE A-5.

RATIO OF AVERAGE INCOME OF PHYSICIANS TO AVERAGE COMPENSATION OF ALL EMPLOYEES, UNITED STATES AND SELECTED COUNTRIES, 1965-1987



SOURCE: Congressional Budget Office calculations based on data from the Organization for Economic Cooperation and Development, Health Data File, 1989, as reported in the *Health Care Financing Review, 1989 Annual Supplement*.

NOTES: Data for the following years were missing and values were imputed by the Congressional Budget Office: 1971, 1976, 1980, and 1984 for the United States; 1966, 1967, 1969, 1970, 1972, and 1973 for West Germany; and 1985 for Japan. Data missing at the beginning and end of the time periods were not imputed.

The concepts and methods of estimating used to compile average compensation per employee are not the same across countries, nor necessarily within each country over time. Among the issues that cannot be taken fully into account are the regional or national basis of the estimates, whether or not both salaried and self-employed professionals are included in the figures, the exact nature of the professional groups covered, the treatment of part-time workers, and whether or not the income definitions used reflect income-tax, census, or national-accounts concepts.

TABLE A-5. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1996

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996
In Billions of Dollars												
Total Federal Spending	118.2	195.6	322.3	590.9	946.3	1,251.7	1,401.6	1,476.2	2,493.2	1,548.4	1,549.1	1,632.3
Federal Health Spending	3.1	13.9	29.5	61.8	108.9	168.0	188.6	214.0	235.3	259.3	286.2	318.4
Medicare	n.a.	6.2	12.9	32.1	65.8	98.1	104.7	116.9	128.3	142.1	157.7	176.7
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	50.8	58.7	66.2	74.7	84.1	94.7
Veterans Affairs	1.3	1.8	3.7	6.5	9.5	12.1	12.5	13.9	14.4	15.3	16.0	16.9
Other	1.5	3.2	6.1	9.2	10.9	16.6	20.6	24.4	26.3	27.2	28.3	30.1
As a Percent of Total Federal Spending												
Federal Health Spending	2.6	7.1	8.9	10.5	11.5	13.3	13.5	14.5	15.8	16.7	18.5	19.5
As a Percentage of Federal Spending on Individual Health Programs ^a												
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare	n.a.	44.6	43.7	51.9	60.4	58.4	55.5	54.5	54.5	54.8	55.1	55.5
Medicaid	9.7	19.4	23.1	22.7	20.8	24.3	26.9	27.4	28.1	28.8	29.4	29.7
Veterans Affairs	41.9	12.9	12.5	10.5	8.7	7.2	6.6	6.5	6.1	5.9	5.6	5.3
Other	48.4	23.0	20.7	14.9	10.0	9.9	10.9	11.4	11.2	10.5	9.9	9.4

SOURCE: Congressional Budget Office calculations and projections.

NOTES:

Medicare expenditures are shown net of premium income.

"Other" includes federal employee and annuitant health benefits, as well as other health spending.

"Total health spending" excludes spending for the CHAMPUS program.

The baseline numbers shown do not take into account discretionary caps. A small portion of the increase in share of the federal spending accounted for by health in 1990 to 1996 is the result of substantial spending for deposit insurance in the first years of this period and which will be recovered during the latter years.

a. May not add to 100.0, because of rounding.

TABLE A-6. AVERAGE ANNUAL RATES OF GROWTH OF REAL MEDICAID PAYMENTS AND RECIPIENTS, FISCAL YEARS 1975 TO 1989 (In percent)

Eligibility Category	1975-1981	1982-1988	1988-1989
All			
Payments	6.2	5.0	6.9
Recipients	.0	0.6	2.6
Aged			
Payments	6.7	4.3	3.5
Recipients	-1.2	-0.9	-0.9
Disabled and Blind			
Payments	11.7	6.3	7.3
Recipients	3.8	1.8	3.0
Children in Low-Income Families			
Payments	0.6	5.2	12.6
Recipients	.0	0.7	2.8
Adults in Low-Income Families			
Payments	2.8	2.5	12.0
Recipients	2.3	0.8	3.9

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HCFA) 2082 Reports.

NOTES: These data show federal and state expenditures for *Medicaid-covered services*. They exclude Medicare Part A and Part B premiums for dually enrolled people, premiums for capitation plans, program administration and training costs, and payments for state-only enrollees or services. The exclusion of Medicare premiums is particularly problematic and results in an underestimate of expenditures for the elderly and disabled.

Recipients are Medicaid enrollees for whom a payment was made during the reporting period for a Medicaid-covered service.

The GNP fixed-weight deflator was used to calculate Medicaid payments adjusted for inflation.

TABLE A-7. MEDICAID PAYMENTS AND RECIPIENTS, FISCAL YEAR 1989

Eligibility Category	Payments (Millions of dollars)	Recipients (Millions of people)	Payment Per Recipient
All	54,500	23.5	2,300
Aged	18,560	3.1	5,900
Blind	410	0.1	4,300
Disabled	20,480	3.5	5,900
Children in Low- Income Families	6,890	10.3	700
Adults in Low- Income Families	6,900	5.7	1,200
Other and Unknown	1,270	1.2	1,100

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HCFA) 2082 Reports.

NOTES: These data show federal and state expenditures for *Medicaid-covered services*. They exclude Medicare Part A and Part B premiums for dually enrolled people, premiums for capitation plans, program administration and training costs, and payments for state-only enrollees or services. The exclusion of Medicare premiums is particularly problematic and results in an underestimate of expenditures for the elderly and disabled.

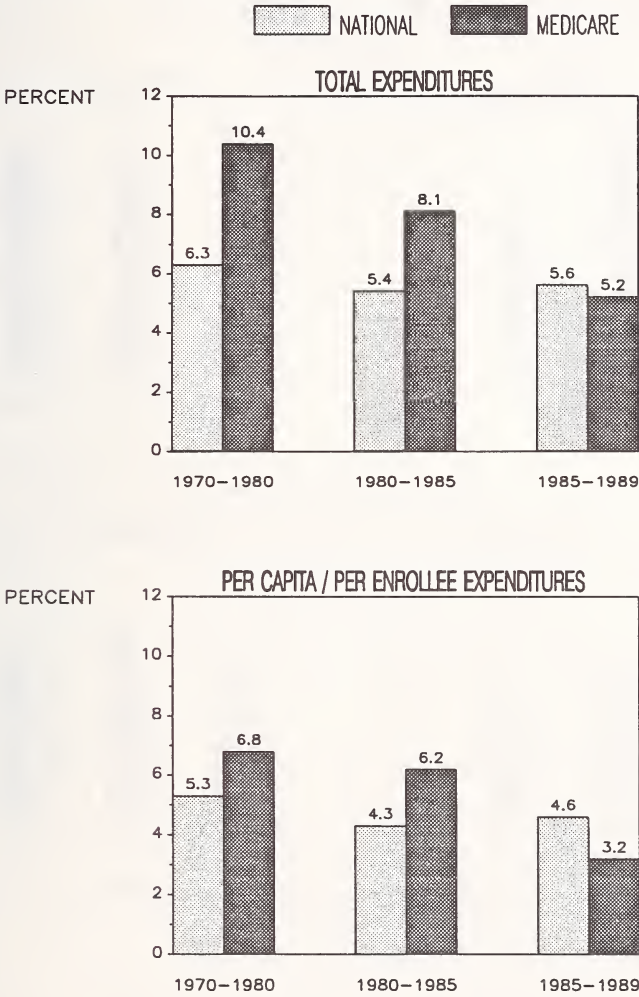
Recipients are Medicaid enrollees for whom a payment was made during the reporting period for a Medicaid-covered service.

The 2082 reports break out the numbers of Medicaid recipients by eligibility category. If a recipient's eligibility category changes during the year, that individual will be counted in more than one category. The total number of recipients is, however, unduplicated. This means, for example, that the percentage of Medicaid recipients who are children in low-income families cannot be estimated exactly, although the built-in error is small.

Components may not add to "All," because of rounding.

FIGURE A-6.

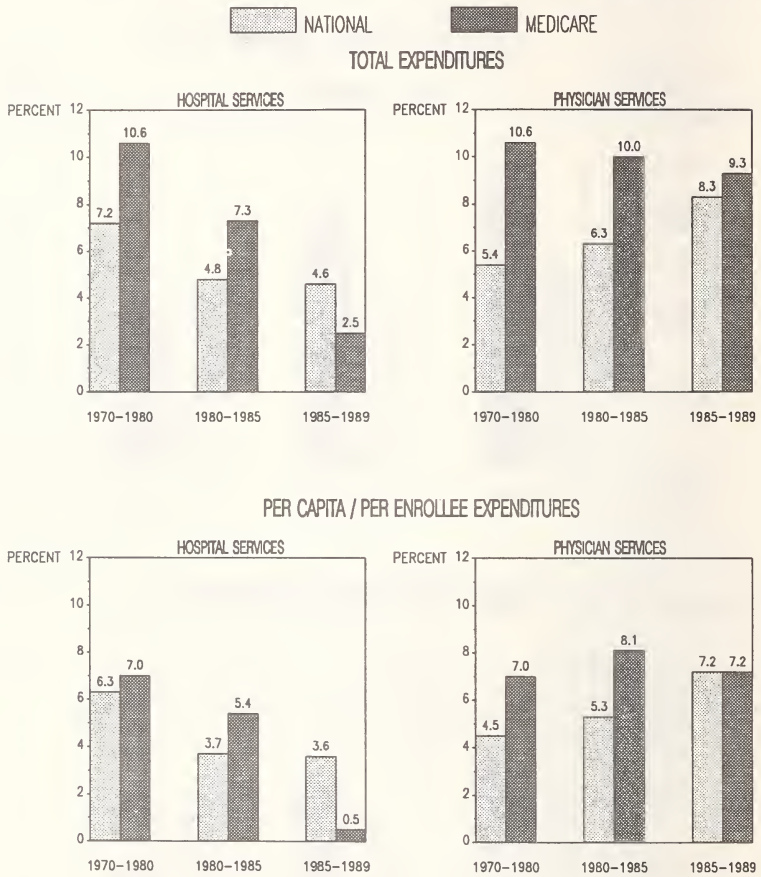
AVERAGE ANNUAL GROWTH RATES OF REAL NATIONAL AND MEDICARE EXPENDITURES FOR HEALTH, TOTAL AND PER CAPITA, 1970-1989



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTE: Real expenditures are calculated using the GNP fixed-weighted deflator.

FIGURE A-7.
AVERAGE ANNUAL GROWTH RATES OF REAL NATIONAL AND MEDICARE EXPENDITURES
FOR HOSPITAL AND PHYSICIAN SERVICES, TOTAL AND PER CAPITA, 1970-1989



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTE: Real expenditures are calculated using the GNP fixed-weighted deflator.

Mr. WAXMAN. Thank you very much. I want to thank you and your staff for preparing this excellent report for us. It gives us a lot of information about what is happening and what is likely to happen in the health care area.

In your statement, you indicate that health care costs are rising much more rapidly than wages, and you suggest that this will result in a further decline in the number of firms offering health insurance coverage to their workers and dependents because employers will simply be unable to afford the benefit and remain competitive. I would like you to elaborate on this. If we do nothing, how much further do you think the proportion of workers covered will decline, and in which sectors of the economy or which portions of the country would you expect this decline to occur?

Mr. REISCHAUER. We don't have an analysis of that sort, and it would be, I think, very difficult to provide anything more than a general answer. I think the general answer is that we can be pretty sure that the fraction of the workforce covered by employment-based policies will continue to decline.

I would think that declines would be most severe in industries where workers are, by and large, paid low wages and have low productivity increases, because then there is less in the way of increased compensation potential that could be divided between wages and fringe benefits.

Those industries that are characterized by one substantial fraction of the industry not having insurance and the other fraction offering it also will be where you see the declines concentrated. There will be competitive pressure within the industry, and also probably in the areas of the country where health care costs are highest and growing the most rapidly.

Mr. WAXMAN. The other side of this question is, if we are going to see a drop in employer coverage for health care, it is obvious we are going to see an increase, I would expect, in the number of people that will be uninsured. Do you have any idea what that trend is going to look like?

Mr. REISCHAUER. If the trend of the last decade continued, we would probably see another 10 million or so people uninsured by the turn of the century and a rise of a couple of percentage points in the fraction of the nonaged population that was uninsured.

Mr. WAXMAN. Let me ask you about the implications for doing nothing for the States. The current CBO policy base line assumes that over the next 5 years State Medicaid spending will increase from \$38 to \$71 billion, and, of course, current policy means just that, that States would continue to cover less than half of the poor, would continue to pay the miserably low reimbursement rates for physicians' services, which was recently documented by the Physician Payment Review Commission.

The rate of increase in State spending that you project implies a major shift in funding priority at the State level. According to the State budget officers, the percentage of State budgets spent on Medicaid will increase from an average of 14 percent this year to an average of 17 percent in 1995. This would imply smaller portions of State budgets for education, prisons, and everything else that they do. Do you think that these rates of increases are sustainable?

Can the States really continue to finance an acute care program for the poor as well as a long-term program for the frail elderly and institutional care program for individuals with mental retardation which is, of course, what Medicaid is about? What about the States with large concentrations of HIV-infected individuals, such as New York, California, Texas, New Jersey, and Florida?

What are we looking at for the States?

Mr. REISCHAUER. We are looking at a very difficult decade. If nothing is done to change this situation, States are going to be faced with the undesirable choice of either cutting other services, eroding the quality of the Medicaid program, or raising taxes. The answer, judging from the past decade, is that they will probably do a little of all three. Some of this will come out of the hides of education, training, and other programs that States provide. Some of it will be taken out of other programs that benefit low-income populations.

I think if we look at what has happened to AFDC payments over the last several decades, in a sense it is instructive. They have fallen in real terms over the past decade, AFDC median payments, by about 22 percent, and I think one contributing factor has been that State legislators have had to choose between maintaining the Medicaid program and providing cash assistance to the low-income population. That will likely continue.

We will also see the quality of and reimbursement levels of the Medicaid program chipped away at, and at some point this will create serious access problems where fewer and fewer providers are willing to accept Medicaid patients.

Mr. WAXMAN. I think we have reached that point already.

Mr. REISCHAUER. We are sort of at the start of it, and it could become increasingly serious. So I think you have put your finger on a problem that is going to be more serious, particularly in those States that face rapidly rising costs associated with AIDS.

Mr. WAXMAN. Thank you.

I am going to move on, but just one quick question related to that. On page 6, you have a distribution of personal health care expenditures by source of payment, yet you show the State and local governments sort of flat. Is that because everything else is increasing more?

Mr. REISCHAUER. Remember, we have a total pie here that is increasing at 12 percent a year. If State spending grows at 12 percent, which is a very hefty rate of increase, the fraction stays the same.

Also, to the extent that uncompensated care has declined because private insurance has picked up more of the tab, you will get less spending for community hospitals, and less public subsidizations to those hospitals.

Mr. WAXMAN. Thank you very much.

Mr. McMillan.

Mr. McMILLAN. Thank you, Mr. Chairman.

I don't think any of us challenge the fact that there are enormous unmet needs in the medical care system. What I am concerned about is, we don't see very easily the resources to deal with them, and I think you have testified as such, that the trend of health care costs increasing as it has, or in consideration of other

budget constraints, put us in a position where we are really unable to deal with those unmet needs except on the margin. I think it really gets to the fact that we are yet to really candidly address the causes of the rapid increase in medical care costs, as you defined it in one way, 4.5 percent real over and above inflation.

Mr. REISCHAUER. Per person.

Mr. McMILLAN. Per person, yes.

It is getting worse. We are not moving any closer to being able to resolve the unmet needs; we are moving further away from it, the way the system is operating. I have become more actively concerned about this as I became a part of this committee and tried to dig into it in a lot of ways, in my own community, in the Budget Committee, and this committee.

We often do a pretty good job of defining the bad news of the way costs are rising, but we don't do a very good job of defining what is driving those costs up, and sometimes I think we tend to focus on the less significant and fail to address the really significant reasons for it. You can get differing views of what those factors are, but I am going to throw a few out just for your commentary, not that I think they are exactly accurate, but I think they need to be examined with some care, difficult as they are to examine.

The first, really, would be what we call defensive health care costs, which are really a spinoff of liability costs. No one argues that anyone who has been damaged by medical malpractice should be compensated, I don't question that for a minute, but that is only a fraction of the cost consequences. The real effect of an entrepreneurial liability system that we have in this country is not only the high liability insurance costs but the things that the system does to protect itself against potential liability.

I have asked that question, for example, of Secretary Sullivan in testifying before the Budget Committee, and he estimated them to be as high as \$150 billion a year. They subsequently raised some question about that, so I won't hold him to that figure, but it illustrates the fact that it is difficult to define.

There are some things that are clearly defensive; there are other things doctors do simply because the equipment is there and it is not being used right now, and if they use it Medicare gets billed for it, and if they don't, then they don't recover a certain portion of the cost on that machine.

But if I go and ask hospital administrators in my district—and we have got some good hospitals—what the proportion of defensive health care costs of their total bill is, they will put it somewhere in the range of 20 percent, which isn't far from what Secretary Sullivan was saying, at \$150 billion out of total medical care expenditures in this country of 650-odd.

You know, just to elaborate a little bit, I asked one rural hospital, which is a 200 bed hospital and has a CAT-scan machine, to give me an example of defensive health care in their facility, and they said, "Well, we just had one this morning. A patient on Medicare came in with a headache, and the first thing she got was a CAT scan, not aspirin, and Medicare got billed \$1,000." You know, normal procedure would be, "Well, why don't you take some aspi-

rin and come back tomorrow if the headache persists"—that sort of thing.

I was talking to a drug company, the United Pharmaceutical Co., that operates in the United States and the United Kingdom, and its volume of business in the United Kingdom is maybe one-fifth of what it is in the United States, but on their legal staff in the United Kingdom they have one attorney, and on their legal staff in the United States they have 80, and the legal director of that company was very quick to—I'm talking too much, I see.

I haven't even gotten but to the first point that I wanted to talk about. Others I wanted to mention were excessive overhead in the system, application of marginal technology advances when we haven't even amortized the cost of the old system, the enormous costs of terminal health care in this country in cases where there is almost no room for improvement in the patient's condition.

I will stop at that, but my point being that I would like to see—and the Congressional Budget Office, I suppose, could do it as well as anyone—a real focus on some of these to try to cast light into some dark corners, because I believe that the wherewithal to deal with unmet needs already rests in a system that is spending well over 20 percent more per capita than the next highest system in the world that is purportedly providing universal health care, and that if we address these things honestly we can find a way to meet the unmet needs within our means, and I think that is the challenge we face.

Mr. WAXMAN. Mr. Reischauer, I want you to respond to that, but let me urge that you only touch briefly some of the major points, because this is a topic that is very meaty and I wish we could get into in depth, and maybe we will with some of the other questions, but other members want to have their chance to ask questions too.

Mr. REISCHAUER. Okay. The first cause you noted was what you called intensive health care associated with the fear of malpractice, and that certainly is important, but I am skeptical that changing the malpractice system would result in substantial change in the rate of growth or even in the level of spending for the simple reason that there are other forces that cause the same type of behavior.

We have a system in which doctors are asking the simple question: Can I find out something from this test or this procedure that will help my diagnosis from a medical standpoint, not from a cost-benefit standpoint? They have no incentive to say: Is the information I find from this CT scan going to be worth \$1,000? So I think we would likely see a lot of this sort of overintensive medicine even in a different malpractice environment.

Most other countries use regulation of both price and volume to control medical costs. We have used the marketplace to do this, and the marketplace has been singularly ineffective, because the individual who is purchasing the product supposedly don't face the real price. They face a sale price, in the sense that their copayments may be only 20 percent, or 15 percent, or sometimes zero—and often they don't even make the decision themselves because these issues are so complex, they delegate to the doctor the decision of do I need to come again? what do I need to have done to me? They have little idea of what they are going to have to pay or what

the total procedure costs, and even the doctor often doesn't have much of an idea.

You mentioned in passing the sort of excess capacity, which we certainly have. I mean we have, as you know, seven times as many MRI's in this Nation as Canada, and we basically have no restraints on the proliferation of these devices or various kinds of technology. Once the capacity is there, the supply, in a sense, creates its own demand, because doctors are in a position to determine what patients demand and, rather than aspirin, a CT scan is prescribed.

Your comments with respect to excessive overhead are certainly true, and they relate to the fact that we have a complex multi-payer system with hundreds of thousands of providers. By going to either a single payer or an all-payer system, we could save tens of billions of dollars—probably not the amounts that have been reported in the press of \$100 billion but substantial sums.

Concentration of expenditures in the last year of life is an unfortunate fact, but it is difficult to know what to do about it because people don't come into the hospital with signs on them saying, "I'm going to check out permanently in 2 weeks," and supposedly many people come in who, if they were not treated, would be in their terminal year of life, but they are not terminal because of the care that is provided to them. That is a very difficult issue, I think.

Mr. WAXMAN. Thank you.

Dr. Rowland.

Mr. ROWLAND. My colleague from North Carolina certainly raises a very interesting point for discussion, and you touched on some of that third party payer relationship, people insulated from the cost of medical care until they go to pay their health insurance premium or people who get Medicare—Medicaid, particularly—biomedical ethical issues, abuse of the people which was not mentioned. I think our system is just very much subject to so many different entities that cause the cost of care to go up—the technology that we have in this country, the liability problem. I don't know that I agree with you about the fact that there wouldn't be much difference if we had a different kind of tort system in our country.

But let me get into another area and ask you something about people who receive Medicare now. What percentage of those people would have some other type of means to pay for their medical care? If we did not have Medicare, what percent of those people who now get Medicare would have something—insurance or whatever—that would pay for their system out of pocket?

Mr. REISCHAUER. I don't know the answer off the top of my head. There is, of course, the employer-provided insurance which tends to be Medigap coverage for the retirees, and there is the question of what would happen to that if there were no Medicare. There is, of course, the Medicaid system which right now picks up for low-income elderly and the aged and disabled and blind with low incomes, the copayments and the premium amounts. Supposedly those folks would end up completely covered by Medicaid.

We had a situation, of course, before the passage of Medicare in which a very substantial fraction of the elderly in America had no coverage at all.

Mr. ROLAND. I hear from a hospital administrator who tells me that he has an individual come into the hospital who is relatively wealthy and has some insurance and he is covered by Medicare. Medicare is paying the large part of his hospital expense, and, in fact, he had the means to pay for that otherwise.

So my question is, if we were to means test Medicare, how much savings would there be? How many people out there have the wherewithal to pay for their health care without going to Medicare? and what would we save if Medicare was means tested, allowing those people to pay for their care because they had some other way to do it?

Mr. REISCHAUER. There are an infinite number of ways to means test Medicare. Some of the ways that people have suggested are to take the insurance value and subject it to taxes, or take the subsidy value from the general taxpayer and subject that amount to taxes.

A more draconian approach, which I think is what you are talking about, would be to say people over some particular income level are not eligible for Medicare and have to buy their own private insurance. The savings would depend on what level you drew the line.

The aged in America, while their incomes have improved markedly over the last couple of decades and on certain measures, they are in fact, better off than families with children and younger families, there are not a whole lot of them with very high incomes. We are talking about health insurance for an elderly population and an item that would be pretty expensive to buy—more than several thousand dollars—and so you have to ask, well, at what level of income—\$30,000, \$40,000—do you want to put the whole burden on that elderly population. It would make a big difference to Federal savings exactly where you drew that line.

If you would like to give us some numbers, some income levels, we could go back and try and calculate the savings for you.

Mr. ROLAND. I guess what I am asking is, how many people already have some form of insurance tied in with their retirement program, or whatever, that would not really need Medicare but would rather depend on the programs that they had in place? That is my question. I am not talking about some income level—you know, the cutoff. How many people now have other health insurance?

Mr. REISCHAUER. Federal retirees and maybe some State and local retirees. I think the rest tend to be largely Medigap policies. The question, of course, would be if the private employers were suddenly faced with the option of dropping health insurance for his or her retired workers versus paying for full coverage costing many thousands of dollars, what would they do?

So the fact that a substantial portion of Medicare recipients have Medigap policies that are provided by their employers doesn't lead automatically to the conclusion that, if we yanked Medicare away from those individuals the corporations would come forth and say, "Well, we will provide you with the full array of health insurance coverage." More likely than not, I think they would drop the coverage entirely if they were capable of doing that legally.

Mr. WAXMAN. Thank you, Dr. Rowland.

If the gentleman would just permit, if a worker is eligible for Medicare and they have private insurance, right now the law would have that private insurance pay before Medicare would pay.

Mr. REISCHAUER. That is true for working——

Mr. WAXMAN. Working elderly.

Mr. REISCHAUER. Working elderly.

Mr. WAXMAN. Working Medicare recipients.

Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

By the way, that last point you just made, that is not the way, based on the information I received from some of my constituents, that it works in practice. I am told that there are many instances where, in fact, the private insurer strongly encourages, if not really directs, that that go to Medicare for payment rather than——

Mr. WAXMAN. Maybe Dr. Reischauer can comment on that.

Mr. BILIRAKIS. I don't know whether you have any comments, but in practice I am not sure it works that way.

Mr. REISCHAUER. I think the chairman described what the law is on the books. The practice may be, as you suggest, a little bit different, and I think there was a recent HHS report that suggested that more should be done to enforce the law.

Mr. BILIRAKIS. Mr. Chairman, as you know, I am in my district 50 out of 52 weekends a year; I go down often. I go to a social event, a wedding, or whatever it might be—I was in a barber shop the other day the entire 40 minutes or 30 minutes, the entire conversation was on this subject. So it is out there at all levels, at all ages, even the Medicare recipients who are probably, in general, are more knowledgeable on this subject than many of the younger people. They basically consider it the number one issue. So there isn't any question that something must be done, and the more we learn, of course, the better, but at some point we are going to have to sit down and start drafting it.

Let me ask you, Mr. Reischauer, about the \$650 billion a year expenditure for medical care in this country. In your opinion, would that amount adequately cover what is needed to cover all needed medical care, if it were redistributed, and reworked in different ways?

Mr. REISCHAUER. There certainly is a substantial fraction of medical care that is unneeded or inappropriate, and if there were some way to eliminate that entirely, the answer to your question would be definitely yes. But it is a little like eliminating fraud, waste, and abuse from government spending. There is no line item in the budget that says "fraud" or "waste" or "abuse," and so it is very difficult to ferret this out.

Mr. BILIRAKIS. No. I appreciate that.

Mr. REISCHAUER. Also, we could rearrange or change our system of delivery in rather radical ways, and if we did that there is every indication in some of the estimates that we have made that the entire population could be covered, spending the amount of money we spend now, but it would involve giving up the advantages of our current system that I discussed before.

Mr. BILIRAKIS. Of course. I think that certainly has to be done, the protected medicine aspect and all other areas that have to be addressed.

In your testimony, sir, you briefly list possible options to expand access for the uninsured. You then state—and I quote:

Because all of these proposals would raise national health care spending and the Federal deficit, enacting any of them at a time when spending for health is growing at an annual rate of 10 percent to 12 percent a year would be difficult unless policies that would effectively control costs were also put in place. To date, however, our varied efforts to contain health care costs have been notably ineffective.

This has been addressed earlier, too, but this is certainly an accurate description of the grid block policy that we constantly face in examining health care reform proposals.

If we were to go to a universal access system, what types of cost containment procedures, in your opinion, must be built into the system to ensure that the health care system does not take over the GNP?

I realize that this is an answer that would take hours if it were adequately handled, and we don't have that much time. I would appreciate it if you would take the rest of my time to try to address it and then for the record, and hopefully we could personally receive copies of whatever is submitted to the record, Mr. Chairman—the remainder of your answer.

Go ahead, sir.

Mr. REISCHAUER. Well, effective ways to hold down costs, I think, would involve an all-payer or a single-payer system so there was uniformity, and also some mechanism for controlling volume responses. There are various regulatory approaches to this, such as providing global budgets for hospitals, providing expenditure targets or limits for physicians' services, and some form of utilization review that had teeth in it.

These are the devices used by other countries which have had greater success in holding down the rate of increase of spending in their systems. Once again, I would note, we give up a number of these desirable dimensions of our current system when we do that.

Mr. BILIRAKIS. Would you submit additional information?

Mr. REISCHAUER. Yes, we will.

Mr. BILIRAKIS. Thank you.

[The information follows:]

Our review of the available evidence on the effectiveness of various strategies for controlling health care costs suggests: (1) If the goal is to control the level and rate of increase of overall health spending in the nation, then policies that encompass the entire health care system—rather than segments of it—would be necessary. Partial controls on spending for health are more likely to shift costs to some less controlled segment of the market than to reduce costs.

(2) No single policy to control health care costs, if adopted in isolation, is likely to be effective. Increases in per capita spending for health can come from higher prices, a larger volume (either number or quality) of services per person, or less efficiency in the provision of services. Consequently, a coordinated set of policies would be required—policies designed to control both price and volume, while assuring that quality would not be compromised.

One policy combination that could increase the ability to control costs, while minimizing the direct impact on patients, would include: Uniform payment rates for all providers in a given locality; uniform utilization review procedures applied to all providers in the locality; and planning for and controls on medical facilities and capital-intensive technologies in the locality.

If applied by only one payer in our multipayer system, this combination of measures might be successful in reducing that payer's costs for its insured population. But the affected providers would probably recover some or all of their lost revenue by increasing prices for other patients, or by increasing the volume of services provided to them. As a result, national spending for health might not be reduced by much. Further, each individual insurer's ability to control costs is very limited in a multipayer system because strict controls by any one insurer will threaten access for that payer's insured population, if providers come to prefer other groups with less restrictive payers.

If only prices were controlled (even if by all payers), it is likely that providers would circumvent the effects by increasing the volume of services provided or reducing the quality of care. If only utilization review procedures were put in place to control volume and assure quality, providers could circumvent the effects on revenues by raising the fees they charge.

The development and dissemination of practice guidelines and changes in the medical malpractice system could also be a useful component of the utilization review process. Physicians might be more cost conscious in their decisions if guidelines were available and concerns about liability were reduced.

Regulation could ensure that adequate, but not excessive, capacity existed to provide necessary services. Without planning, excess capacity is likely to develop. In this case, if controls on volume were not entirely effective, the existence of excess capacity would lead to greater use of the services provided by the facilities than was necessary for appropriate care.

The level of effectiveness of these strategies—and of other approaches such as increased cost sharing for consumers and expenditure limits—would depend upon the stringency of the controls on prices, utilization, and technology that would be put in place. The impact of these strategies on access to new technologies, waiting times for services, and consumers' freedom of choice of providers, insurance coverage, and treatments would also depend on how stringently the cost control policies were applied.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Mr. Studds.

Mr. STUDDS. Thank you, Mr. Chairman.

Mr. Reischauer, let me just pick up where Mr. Bilirakis left off. This is the not the first time that the country as a whole was ahead of those who purport to represent them. I think there is a broad understanding in the country that the system is catastrophically deficient and needs to be reformed fundamentally, and I have the same experience day after day, week after week. I am even being summoned to meetings rather than calling them myself these days.

I had 1 day a few weekends ago where I went from a group of 300 or 400 people in a city where unemployment was approaching 20 percent. Not surprisingly, I asked for a show of hands as to how many people were uninsured, and roughly one-third of the hands in the room went up, because of course the next thing you lose after your job is your insurance. I then asked how many seriously, genuinely were frightened that somewhere in the next year they might become uninsured, and virtually every hand in the room went up.

I then moved to a totally different setting of a very profitable company, of which I don't have a great many these days, employing some 250 people. I went there because I had received 250 postcards from the employees asking me to come and discuss health care, and I met with their CEO first, and he said, "Look, we are expanding, we are prospering, we are competing with the Japanese in automobile components"—you don't hear that too often—we are very particularly proud of our insurance; we have a sort of Cadillac

insurance program for our employees, but for each of the past 5 years the cost of that has gone up 50 percent, so we have had to introduce an Edsel—we can't afford the Cadillac any more—and give people an option.

Finally, I went to a local chamber of commerce, where I don't usually over the years spend a great deal of time nodding my head in agreement with all the people around the table, and most of these were small business people, small employers. At the end of the meeting, the local executive director rushed out to the telephone, and I said, "Where are you going?" and he said, "I'm going to call the national chamber of commerce and tell them to get with a universal system of health care." I thought I was going to faint. I never heard such a response. It is everywhere and, as Mr. Bilirakis said, at all levels.

For that reason, I was a little bit surprised, and I guess I know why, that you looked at three options, as I understand it—an employer-based option, a Medicaid expansion option, and a combination of the two. I assume that was because that was what you were asked to do and you were limited by the requests of the two committees.

Mr. REISCHAUER. We also have another paper that examines extending a Medicare-like system to the entire population. So you have to read two volumes, but the answer is there.

Mr. STUDDS. Has that been released already?

Mr. REISCHAUER. No. It will be released in a few weeks.

Mr. STUDDS. So that essentially would be a universal single payer system?

Mr. REISCHAUER. Yes.

Mr. STUDDS. Are you able to reflect a bit? I mean I am sure you have seen the GAO study released a month or so ago on the Canadian system. I think most of the people at this table went together to Canada with Mr. Waxman a few months ago, and while I think none of us came back with the feeling that if we had a magic wand we would transplant it immediately intact, I think—I will speak only for myself—I came back embarrassed and angry at some of the contrasts I saw.

Mr. REISCHAUER. If I can make an observation on your original statement, which I think really is quite accurate, that there is growing dissatisfaction with the current system and a lot of anxiety that at some point in the future every American might find themselves without health insurance, or their children leaving college and going to work will be without health insurance, I think that is all very true. But I think we should keep in mind that probably the only thing people will dislike more than the current system is whatever is proposed. We saw a little bit of this in the reaction to catastrophic insurance under Medicare.

Mr. STUDDS. Catastrophic was a classic.

Mr. REISCHAUER. Well, let me just continue and suggest why I think this might be the case, and that is, virtually any of the alternatives that we are considering proposing looking at involve tremendous amounts of redistribution. There are many people in America—and I am one of them—who are overinsured. I am covered by my wife's policy, and I am covered by my own policy. I don't like the hassle of all the forms that I have to submit, but, let

me tell you, the out-of-pocket amounts that I pay are infinitesimal. Many people would be considerably worse off under most of these proposals.

Let me just describe what I see as one of the most difficult hurdles for a universal system of the sort that you are talking about. How are we going to pay for it?

Right now, we pay for employer-provided health insurance in a tremendously regressive way, basically through a head tax on every employee in the company. What the employer is actually doing, according to economic theory, is lowering the wages of every employee by whatever his premium is, say \$2,500. So the \$10,000 secretary is having her wage dropped by \$2,500, and the \$150,000 executive is having his wage dropped by \$2,500.

Mr. STUDDS. You are making a very good argument for financing the whole thing from a progressive income tax.

Mr. REISCHAUER. I am not talking about the equity issue or where my values are. The other portion of it comes from government support both in the form of the tax subsidies that I mentioned and in the form of direct spending for Medicare, Medicaid, or whatever. Some of that is progressively financed through the Federal income tax, some of it comes from State sales taxes. As a whole, it is a tremendously regressive system.

So we will have a situation in which a substantial portion of the population—middle class and upper middle class, who now have pretty good coverage—will end up paying substantially more for a health care system that may not provide them with much improvement in the way of benefits. They are relatively well covered now. Rather than having the head tax of \$2,500 plus the monthly charge of \$30 or whatever they might pay to their employer for their share, they will be paying, let's say, a payroll tax maybe of 7 or 8 percent or an income tax surcharge. Rather than paying \$3,000 in reduced wages and direct payments for this health care system, they will be paying \$7,000, or \$8,000, or \$9,000 if the rates were progressive.

Mr. STUDDS. You are talking me into it.

Mr. REISCHAUER. As I said, I am not trying to describe where my values are on this, I am just making a prediction on looking back a few years at the response to the catastrophic health insurance initiative by the elderly who were well covered already and asked to pay more. I suspect there might be a similar kind of reaction among the broad middle class.

Mr. STUDDS. I know my time is up before I got to my point.

Mr. REISCHAUER. And it is basically because the American people don't really realize now—why everything sounds attractive is, they don't really understand how health insurance is being paid for now.

Mr. WAXMAN. Thank you very much, Mr. Studds.

Mr. STUDDS. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

Dr. Reischauer, I am looking at page 8 of your testimony, your principal testimony. You point out that a small fraction of the population each year accounts for an exceptionally higher proportion

of total spending for health care. Reading from your report, you say:

In 1980, 50 percent of the population with the lowest health bills accounted for only 2 percent of total health spending, while the 10 percent with the highest expenditures accounted for 75 percent.

Who are the 10 percent? Is there any way to characterize who they are or why they are ill?

Mr. REISCHAUER. The seriously sick. Many people have virtually no health costs during a year, and even if you looked at the Medicare program back several years ago, you would find that about 20 percent of the Medicare participants didn't spend enough to reach the \$75 deductible amount, and so you have a healthy year. Or you have a 16-year-old child who doesn't go to the doctor for a year. At the other extreme are those who are having heart transplants or back surgery, who have been in an automobile accident, or are suffering from cancer. Those are the people one finds in that category where expenditures are extremely high.

Mr. BRYANT. Is there any way to characterize who they are or where they have come from, why they are ill?

Mr. REISCHAUER. The relative distribution doesn't look a lot different for the elderly versus the nonelderly. I mean if you looked at the under 65, you would find that a very small fraction of the nonelderly account for three-quarters of the spending, and the same is true for the elderly, so we can't say it is elderly versus non-elderly. Some people in both groups have to have major, mostly hospital-based, treatments.

Mr. BRYANT. If, in fact, 75 percent of the money this Nation spends on health care is being spent on only 10 percent of the people, it would seem to me that that would be a very fertile area for us to examine with regard to trying to cut the cost of health care in some fashion. Is there any way to service the 10 percent so that they are not so sick? Is there any means by which we could prevent them from becoming ill by starting much earlier? Is there any kind of a history for or any way to typify this 10 percent?

Mr. REISCHAUER. I don't think so. I think you have a mixture of, as I said, people who have been in automobile accidents, and you could pass a 40-mile-an-hour speed limit law; people who have cancer, and you could outlaw cigarettes; people needing a heart transplant, and you could mandate that everybody eat a high-fiber diet and that we not allow cattle to be raised in America.

Mr. BRYANT. That is an outrageous suggestion—the last one.

But I know what you are getting at. The fact of the matter is, though, that the chairman of this subcommittee, along with the rest of us, has proposed a couple of those or something that relates to a couple of those suggestions right there, particularly regarding smoking. I mean it seems to me we ought to be looking at that if, in fact, that would have a measurable impact on the 10 percent—all of these proposals.

That is, I guess, what my question is getting at, whether or not it is worthwhile to examine the 10 percent and see if there is not something we could do with regard to prenatal care or early childhood preventative efforts, smoking, diet, and so forth.

Mr. McMILLAN. Let's broaden this thing out and include the automobile and see if we can get the chairman of the full committee on this.

Mr. BRYANT. Well, certainly the tendency of the automobile to pollute ought to be taken into consideration, if not the speed limit. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bryant.

Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman.

I note that you answered our colleague from Massachusetts with a statement that we are sort of financing health care now by a head tax which is quite regressive of about \$2,500, and the alternative would be a \$7,000 to \$9,000 hit for upper-income people on their income taxes.

In addition to that, you say to control costs would impact the freedom to choose insurance coverage, providers, and so forth. You don't come out with any direct suggestions.

I assume you are familiar with the GAO report that says our proliferation of payers of maybe 1,500 or so is costing this country big bucks, and I assume you are familiar with the article in the New England Journal of Medicine of May. Both of these indicate that the range of savings we could get by going to a single payer system would be, on the bottom end, \$60 to \$70 billion and, on the top end, up to \$100 billion, and another estimate is \$130 billion in savings annually.

The Rockefeller report indicated that the total cost of our going to a national health program that would include all of us, including the 37 million uninsured, including catastrophic programs not only for the elderly but for the rest of the population, long-term care for the elderly as well as the rest of the population, the savings by going to a single payer system would more than pay the entire cost of going to a vastly improved health care program that would include all of our population and all of our health needs.

So it seems to me that there is sort of a challenge for you here. There are a lot of lesser important savings available—knowing better what treatments, what medical procedures, drugs, operations, x-rays, CT scans, whatever, when to apply them. There have been estimates that up to a quarter or a third of those procedures are unnecessary. The medical malpractice business has a price tag of \$10 or \$12 billion a year. But on the big possible source of savings that we could achieve in one fell swoop of going to some kind of a single payer system, perhaps different single payers in each State but, in the aggregate, a single payer system, you are talking, as I say, anywhere from \$60 to \$130 billion—pick your own estimate—which is more than the cost of going to a national health care system.

So I would ask you, is the freedom to choose insurance coverage and insurance providers really worth that kind of tab to the American people?

Sure, I guess a lot of people would say, "I want to pick my own insurance company, I want to pick my own insurance coverage," but, being a devil's advocate and just for the purpose of stimulating a little useful discussion here, what kind of a price tag do you think people would place on their own right to pick their insurance

company, to pick their insurance coverage, and would the prospect of enjoying this phenomenal saving if we went to a single payer system, saving the top bracket payers that \$7,000 to \$9,000 hit based on a progressive income tax, and saving the present head tax, as you describe it, of \$2,500—would such a potential saving be enough to induce the average person to say:

Hey, sure, I'd like to name my company, sure, I'd like to name my coverage, but if I can get this kind of a windfall, continuous windfall every year for the rest of my life, I would be happy to forego that and accept the savings incident to a single payer system along the Canadian model.

But with a good many improvements that we could structure into the system to take care of some of the imperfections that we see in the Canadian system.

In other words, I would like you to factor this enormous potential saving that you and all of us have read about, factor that into your testimony and tell us where you come out.

Mr. REISCHAUER. First of all, you chose the GAO's estimate and the New England Journal of Medicine's estimate, \$67 billion to somewhat over \$100 billion. We have examined the same question, and our number is a bit smaller.

Mr. SCHEUER. What is your number?

Mr. REISCHAUER. Somewhere between \$27 billion and \$56 billion, depending on exactly how you would design the system.

Remember, the GAO is costing out a Canadian system, which pays hospitals with global budgets. If you think that is not likely and we would rather end up with a system in which we paid hospitals per procedure in the same sort of way that Medicare does at this time, we wouldn't save quite the amounts that GAO is suggesting.

But I don't want to quibble over these differences. As you have pointed out, the administrative costs of our current system are substantial. We have factored in savings to our cost estimates and analysis of this extending of a Medicare type system to the entire population that we will release in several weeks. So we have factored that in, and that is, of course, one reason why we say that a system like that could end up costing little or no more than we spend now, while covering the entire population, including the 33 million who now lack health insurance.

Mr. SCHEUER. Covering all of their health needs.

Mr. WAXMAN. You wouldn't agree with that last point, would you?

Mr. REISCHAUER. Covering all of their health care needs? No.

Mr. SCHEUER. Covering all of their health care needs, including catastrophic.

Mr. REISCHAUER. No. We have a universal plan in this paper that we have done which has about the same actuarial value that the current Medicare system has, and, remember, that doesn't cover drugs. Under this proposal, you could actually get about \$140 worth of drug coverage a year in its different elements. It also has coinsurance requirements. It is not a system in which the individual pays absolutely nothing directly and is only hit indirectly through taxes. It doesn't provide complete coverage.

You said facing the American people with this choice, wouldn't they all say, "Sure, sign me up"? and I guess my answer to that is, they will compare what their insurance coverage looks like now to

what this package that they are being offered. A substantial minority would receive less satisfactory coverage than they have now.

Mr. Studds talked about the Cadillac plan that this employer offered. There are a lot of Cadillac plans out there. We are not going to provide Cadillac coverage for the entire population, and there will be all of those people who are now enjoying the luxury of the Cadillac will not come forward and say, "Sign me up."

For the political point of view, these people, I think, tend to be the most articulate and the most powerful members of our society.

Mr. WAXMAN. Thank you, Mr. Scheuer.

Mr. Kostmayer.

Mr. KOSTMAYER. I have no questions, Mr. Chairman.

Mr. WAXMAN. If the gentleman would take his time and yield, perhaps we can avoid a second round.

Mr. KOSTMAYER. I would be happy, Mr. Chairman, to yield to whoever would like to be yielded to.

Mr. WAXMAN. May I make the first request?

Mr. KOSTMAYER. I yield to the gentleman from California.

Mr. WAXMAN. Thank you.

Just to put some things in perspective, are you going to come out with a report that is going to say, if we covered everybody under Medicare, we would have enough cost savings to pay for everybody that is not now covered? Is that your position?

Mr. REISCHAUER. We are going to give a range, as is prudent at this point, and it will be a range that suggests that a system like that we could end up with national health spending slightly below or slightly above its present level.

Mr. WAXMAN. Does that assume the existing Medicare benefit package?

Mr. REISCHAUER. It provides everybody with a package that is actuarially equivalent.

Mr. WAXMAN. Okay.

What does it assume on cost containment? The same cost containment now that we have for Medicare?

Mr. REISCHAUER. It assumes a single payer system, obviously, with volume controls of the sort that we have had or are developing in the Medicare system.

Mr. WAXMAN. But you are assuming the cost controls in Medicare at the present time.

Mr. REISCHAUER. Well, okay, the reimbursement rates—

Mr. WAXMAN. Without global budgets or anything else, we are talking about existing reimbursement rates for Medicare for hospitals and doctors, with the DRG system for hospitals and the RBRVS for physicians, and I see that your staff is shaking their head in the affirmative, so the record can be clear.

Mr. REISCHAUER. I was nodding, too.

Mr. WAXMAN. What has troubled me in this whole debate is that, on the one hand, we say to people, "You don't have to worry; we will provide health care for everybody in this country, and nobody is going to have to pay any more." On the other hand, we say to people, "This is going to cost so much money that I don't know how we as a nation can afford it."

Between those two positions, where do you come out? Do you think we can provide health care for everybody in this country

without paying more money? You already made some reference to the fact that you think there are going to be a lot of unhappy people.

Mr. REISCHAUER. What I am basically saying is, on average, we would not be paying more or much more, but that doesn't mean that that is true for every individual or every group. What I am suggesting is, we have, in a sense, a bizarre way of paying for health coverage, largely a head tax supplemented by some other taxes, and I suspect that that would be an intolerable way to pay for this universal care system.

I mean, if you came out and said, "Well, we are going to slap a \$2,000 head tax on every household in America and then marginally increase other taxes to supplement it," that would be unacceptable.

Mr. WAXMAN. I guess my frustration—and I thank the gentleman for yielding—is that if we look at this as an academic enterprise we could just rearrange a pie and it could all come out fairly rational. The only problem is that we have a lot of people who are going to find reasons to be unhappy, and that is why I have come to the conclusion that the less dislocation the more politically possible some advance might be, and the least dislocation is to leave those who have their insurance, which is most people in this country, require those who are working to be covered by their employers in some way or other—pay or play—and then have the public fund a plan for those who are left out. Doesn't that lead to the least dislocation and therefore the least political unhappiness?

Mr. REISCHAUER. But it probably provides the least in the way of administrative savings.

Mr. WAXMAN. Not necessarily. It could be fashioned with a lot of flexibility.

Mr. REISCHAUER. And you could get into what might be called an adverse selection death spiral in the public sector, which is, any firm that faced very high costs because its employees were sicker than usual or lived in areas where the costs are extremely high, would drop out of the private system and go into the public system, thereby pushing up the cost of the public system and facing the political leaders of our country with two choices: either to raise taxes or to reduce the level of benefits for the public system.

Mr. KOSTMAYER. What might we get for the same price or a little more?

Mr. REISCHAUER. I am not sure I understand.

Mr. KOSTMAYER. In terms of our health care system, what might we get for the same price? What can we get for the same price or a little more?

Mr. REISCHAUER. I am suggesting that if we are looking at this just as an academic exercise and not talking about the political dynamic, we could get universal health insurance coverage.

Mr. KOSTMAYER. For the same price we are paying for our current system?

Mr. REISCHAUER. Yes.

Mr. KOSTMAYER. I came in late, but for the same price that we are paying now or a little more, we could get what?

Mr. REISCHAUER. We could get universal health care coverage with the same actuarial value per person as the Medicare system but extended to the entire population.

Mr. WAXMAN. Without objection, the gentleman from Pennsylvania will be given 5 additional minutes to yield to any member, and that is going to be it. After that 5-minute period, we are going to have to move on.

Mr. REISCHAUER. Let me, since I did come in late—and I apologize—see if I can get this straight. For the same amount that we are paying now or perhaps a little more, we could provide, if we did it differently, coverage—

Mr. REISCHAUER. Very differently, right.

Mr. KOSTMAYER. If we did it very differently, we could provide coverage for virtually everyone in the country, including those nearly 40 million Americans who have no coverage now. Is that right?

Mr. REISCHAUER. Thirty-three million, yes.

Mr. KOSTMAYER. Why don't we do that? It seems so simple. What am I missing?

Mr. WAXMAN. It would not be popular with the rich or the middle class.

Mr. REISCHAUER. You are missing the fact that we have a structure in place now that includes insurance companies, employers, providers, and beneficiaries, some of whom would be hurt by this. Some of the beneficiaries would be hurt.

Mr. KOSTMAYER. But the majority of the people in the country would be helped? I am not just talking about the additional people who would be covered who aren't covered, the 33 million. How about the people who are already covered? Would it be better coverage?

Mr. REISCHAUER. A significant minority—and I am purposely vague because I can't give you a number, but I am sure it is well over 10 percent—would receive a reduction in their benefits. The policy wouldn't be as good as what they have.

Mr. McMILLAN. Would the gentleman yield?

Mr. KOSTMAYER. I would be happy to yield to my friend from North Carolina. I just want to ask about the remaining 90 percent. What happens with them?

Mr. REISCHAUER. Do I have to yield?

Mr. KOSTMAYER. I want to yield to my friend from North Carolina, but 10 percent of the people under the proposal you talked about—

Mr. REISCHAUER. I said substantially more than 10 percent. I am not sure.

Mr. KOSTMAYER. Is it 11 or 91?

Mr. REISCHAUER. It means less than 50 percent, more than 10 percent.

Mr. KOSTMAYER. That is quite a range.

Mr. REISCHAUER. I said I was being purposefully vague.

Mr. KOSTMAYER. Would you be clearer?

Mr. REISCHAUER. I would if I could, but I can't.

The great bulk of the population, I think, would end up with an insurance policy roughly similar to what they have now. Another chunk of the population, certainly those who now benefit from

Medicaid, and those who have limited kinds of employer-provided insurance, would be substantially better off. I am only talking about the benefits, who would be better off or worse off, considering only the benefits.

Mr. KOSTMAYER. Is that, in your view, a net gain?

Mr. REISCHAUER. You know, the director of the Congressional Budget Office isn't supposed to ply you with his value judgments.

Mr. KOSTMAYER. You have done extensive work in this area.

Mr. REISCHAUER. Well, I mean that there is no sort of analytical answer to that question. What we are talking about is redistribution.

Mr. KOSTMAYER. You have got to make an objective judgment.

Mr. BRYANT. Will the gentleman yield?

Mr. KOSTMAYER. I yield to the gentleman from North Carolina first.

Mr. McMILLAN. I don't understand something here. I guess I should wait until I see your full report, but it sounds to me like you are saying that you are going to take the revenues that are paid into the private insurance system today, transfer that into a single payer system at the same rates, and still going to provide them with the same coverage—you just stated that—but then you are going to extend this to those who are not covered, which has been roughly estimated to be in a magnitude of \$25 to \$40 billion a year; I don't know exactly what it is. Where are you going to get the money to do that, unless somebody is going to pay more?

Mr. KOSTMAYER. If I can reclaim my time, what is the administrative cost difference between, for example, the Canadian system and the American system? What percentage of the Canadian system goes to administrative cost, and what percentage of the administrative cost under the American system goes to administration?

Mr. McMILLAN. If I could just add one final note, because I was going to come to that question: Is it cheaper to run a reimbursement program like Medicare or Medicaid, less overhead, than it is to run a private ins program?

Mr. KOSTMAYER. If I could reclaim my time, if the witness could answer my question.

Mr. REISCHAUER. There are different kinds of administrative expenses. There are the administrative expenses of running the program and running the insurance company, and in that sense—

Mr. KOSTMAYER. Do we spend a whole lot of money in the American system on administration that we ought not to be spending?

Mr. REISCHAUER. Yes, we are—

Mr. KOSTMAYER. Is it billions of dollars?

Mr. REISCHAUER. It is tens of billions of dollars.

Mr. KOSTMAYER. Tens of billions of dollars.

Mr. REISCHAUER. Right.

Mr. KOSTMAYER. Couldn't we transfer those billions and billions of dollars into care and away from administration, and isn't that where the money would come from?

I yield to the gentleman from Texas.

Mr. REISCHAUER. You have provided half of the answer to Mr. McMillan's question.

Mr. McMILLAN. Would you sign an audit statement that he answered it correctly?

Mr. REISCHAUER. But he would only receive half credit, because there is another component here: Where would we get the funds to do this? The answer is that we would be reimbursing providers at Medicare rates, which in some instances are below the rates—

Mr. KOSTMAYER. The funds are there, billions of dollars. The funds are there.

Mr. REISCHAUER [continuing]. Which are below the rates at which private insurers are reimbursing providers for the same services. So there are those two components.

Mr. WAXMAN. Mr. McMillan, did you want to ask a last question?

Mr. McMILLAN. I could spend the rest of the day on this.

Mr. WAXMAN. The gentleman is not recognized for that purpose.

If the committee would permit, we certainly obviously have a lot of questions. Your testimony and your charts and your contribution have been very helpful to us and stimulated a lot of thinking. This is not going to be our last time to think about the question. It maybe won't be the last time to have you here to help us think it through, but we thank you very much for being with us today.

Mr. REISCHAUER. I thank the panel.

Mr. WAXMAN. Our second panel is composed of three individuals that bring different perspectives from the private sector to the issue before us this morning: What happens, again, if we do nothing?

Dr. Steven Schroeder is president of the Robert Wood Johnson Foundation, the largest health philanthropy in this country; Mr. Michael Peevey is president of the Southern California Edison Co., the Nation's second largest electric utility; and Mr. Sean Sullivan is vice president of New Directions for Policy, a Washington-based public policy research and consulting firm specializing in health care issues. We are pleased to have these witnesses here today.

Your prepared statements will be in the record in full. We would ask you, if you would, to limit the oral presentation to no more than 5 minutes, and we will have to be quite strict about that 5-minute limitation.

Mr. Schroeder, why don't we start with you.

STATEMENTS OF STEVEN A. SCHROEDER, PRESIDENT, THE ROBERT WOOD JOHNSON FOUNDATION; MICHAEL R. PEEVEY, PRESIDENT, SOUTHERN CALIFORNIA EDISON CO., ACCOMPANIED BY JACQUE SOKOLOV, VICE PRESIDENT AND MEDICAL DIRECTOR; AND SEAN SULLIVAN, VICE PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. SCHROEDER. Thank you, Mr. Chairman, for offering me an opportunity to share my views about the U.S. health care system.

Health care in the United States today presents a paradox. At its best, it is a technological marvel unsurpassed in the world, and we have made major strides in health status in the past two decades, including impressive declines in death rates from heart disease and strokes.

Yet in other ways our health care system is fundamentally flawed. Far too many people do not receive the benefits of our best medical care. For the numerous persons who suffer with chronic illness, the services they receive do not match up well with what they need to preserve their function and to maintain independent lives. We could do much better in understanding and combating widespread destructive behavior, especially substance abuse, and the pressures, as you have just heard, of rising expenditures for medical care and the ineffectual responses to control those costs have created anxiety about health care coverage in almost all citizens have severely interfered with the workings of the health care system and antagonized many of its workers and have threatened many local and State economies. Let me expand for the rest of my time on those issues.

Starting with the problem of medical costs and control, as you just heard, we are the highest in the world in terms of expenditures, and yet our performance as a nation, we are in the second tier of developed countries. There is substantial waste not only at the administrative level but in terms of unnecessary services that are given, and yet this waste coexists with pockets of underservice.

The way we pay for care for the under 65's through employment-based insurance means that many people lack coverage, and many others, as we heard from Congressman Studds, live in fear of losing it.

During the past decade, a variety of largely ineffective cost containment mechanisms have succeeded in driving out nonproductive administrative costs and compounding existing inefficiencies. They have intruded into the daily fabric of ordinary clinical decision-making. They have frustrated patients. It is almost as hard now to figure out how to pay a hospital bill as it is to figure out how to pay your income taxes. They have created widespread anger and cynicism and distrust for doctors, with resulting repercussions in the types and distribution of care provided. So, as a result, we are stuck now with the worst of two worlds: We have out-of-control health care costs and ineffectual and mischievous remedies to try to contain those costs.

I am struck personally by the reluctance of the involved parties—the payers, including government, employers, labor, insurance companies, hospitals, doctors, and the manufacturers of medical devices and drugs—to sit down and resolve the cost containment dilemma. Instead, for the past two decades the country has engaged in a futile search for a single, painless magic bullet solution to the dilemma of rising expenditures for medical care. Each party claims to want the issue resolved, but no one wants to give anything up. It reminds me of politics in Beirut, Lebanon, where each party's favorite solution is unattainable and the second favorite solution is to maintain the status quo.

We move now to access to care. It is a national disgrace that a country as prosperous as this one and with such a substantial investment in medical care permits so many of its citizens to go without basic medical care. We should be embarrassed that so many of our young people lack health insurance, that epidemics of measles are recurring in our cities when a simple preventive strategy is at our disposal, that many women do not receive early prenatal care,

thereby placing them at great risk for either infant deaths or for long expensive stays in the hospitals. Mr. Chairman, it is time for this Nation to state boldly and unequivocally that all citizens deserve access to basic health care.

Concerning that ever expanding part of our population that suffers from chronic illness, our current health care system is not well designed to care for this population. As a nation, we have overinvested in acute care, high technology medicine in the hospital setting with rampant duplication of services, and we have undervalued the coordination of services in the community that will improve function and preserve independence for these many patients.

Our experience has shown—and you have previously heard testimony on this point—that such a reorganization can both improve quality and save costs, but to do so on a wide scale will call for major changes in the way we pay for services as well as how we organize and distribute them. The millions of patients and their families struggling with such conditions as Alzheimer's dementia, AIDS, diabetes, arthritis, and chronic lung disease would all benefit from such reforms.

Finally, as regards harm from substance abuse, this is the single most important threat to the health of our public. We need to learn more, and although progress has been made there is still far too much human tragedy.

In conclusion, we are now at a time of great unease and instability in our health care system. The sense of crisis posed by runaway costs of care and the threat to many of loss of health insurance coverage provides an opportunity to preserve the strengths of our system while reorienting it to be more accessible to its citizens, focus on those in need of help, not just those who provide the help, and give us results that we can be proud of, not embarrassed by.

These changes will require forceful leadership from all sectors, including the Federal Government, and from my experience in health care during the past 25 years I am confident that if you call for such leadership it will come.

Thank you.

[Testimony resumes on p. 74.]

[The prepared statement of Mr. Schroeder follows:]

THE
ROBERT WOOD
JOHNSON
FOUNDATION

Statement of Steven A. Schroeder, President
The Robert Wood Johnson Foundation
before The Subcommittee on Health and the Environment
Hearing on Health Care Reform
July 10, 1991

Good morning, Mr. Chairman and members of the Subcommittee. I am Steven A. Schroeder, M.D., President of the Robert Wood Johnson Foundation. We are the nation's largest philanthropy devoted exclusively to health and health care. Prior to my appointment at the foundation, I held positions at Harvard Medical School, the George Washington University Medical Center, and the University of California in San Francisco, where I was Professor of Medicine, Chief of the Division of General Internal Medicine, and a member of the Institute for Health Policy Studies. I appreciate the opportunity to address you today regarding health care reform.

Let me preface my remarks with a bit of introductory background. Since being established as a national philanthropy in 1972, the mission of the Robert Wood Johnson Foundation has been to improve the health and health care of all Americans. Over the years, the foundation has developed numerous programs to help solve many of the persistent and emerging health problems of the nation. However, it is sobering for us to reflect on the fact that the \$1.1 billion we have invested over the past 19 years to improve the health and health care of Americans is slightly less than what this country spent on medical care in the last 18 hours. Therefore, in order for the foundation to maximize its impact on how the nation delivers health care, we have focused our efforts on catalyzing meaningful incremental change at the federal, state, and community levels.

Our strategies to break down the barriers to health care for all Americans by leveraging the health care system at these three pressure points are especially focused with respect to underserved populations in both rural and urban settings. In addition, we also continue to test mechanisms to make health care more effective and more affordable, and protocols to analyze objectively public policies relating to health care.

Mr. Chairman, the health care system in the United States today is a paradox. Continued improvements in medical science and biomedical technology provide opportunities for improved health that are unprecedented in our history. Never before has a society possessed the means to improve the health and function of so many of its citizens. For some, this is still the best nation to receive treatment for disease. Expertise in organ transplantation, pharmaceuticals, and biomedical imaging have secured world leadership for the United States in medical technology. The United States also has distinguished itself by successfully promoting healthier lifestyles to its middle- and upper-class citizenry, resulting, in a significant decrease of death rates from many diseases, including heart disease and stroke.

But at the same time, as these benefits are establishing themselves among a particular portion of American society, most modern miracles of medical science are out of reach for a significant and growing number of Americans. Unmanageable health care costs, a financing and organization system that encourages fragmented, uncoordinated health care services, and a lack of apparent continuity in health care policy make the United States unable to care properly for an ever-increasing number of its inhabitants.

For many Americans, the health care safety net is not loosely woven, it is nonexistent. At least thirty-one million people are without health insurance, representing not only those who are perpetually uninsured, but a far larger number of people who may be temporarily without coverage during a given year. Not only is health care costing more, it is serving fewer and fewer people. The largest uninsured group is children under the age of 18. In 1987, some 18 percent had no health insurance compared to 13 percent ten years earlier. In a recent survey, 18 percent of Americans said that the cost of care prevented someone in their family from seeking medical care. In households with incomes of less than \$15,000, the figure was 29 percent.

Adding to this atmosphere of crisis are crowded hospitals filled with cases of preventable disease and injury, and an asymmetric system of compensated care that fragments services for those individuals with multiple health needs, adding to cost and inefficiency. And while many experts believe the U.S. health system requires fundamental restructuring, leadership is too entrenched in special interests to come together on solutions.

COSTS

Clearly, for many Americans, the spiralling cost of care is a dominant barrier to accessing health care. Our nation now spends over 12 percent of its gross national product (GNP) on health care and the costs continue to escalate. The United States leads the world by a wide margin in per capita spending for health care. There is increasing concern that the cost of

health insurance for workers is undermining the competitiveness of U.S. business in the world market. Between 1980 and 1989, the average annual increase in the consumer price index was 4.7 percent, while the average annual increase in health care costs was 10.4 percent.

Over the past two decades, the U.S. has experimented with a bewildering variety of cost-containment measures, including health maintenance organizations, utilization review, health planning to prevent overbedding and unnecessary duplication of technologies, price controls, malpractice reform, co-insurance and deductibles to discourage demand, reductions in eligibility and payment levels for those receiving Medicaid, reimbursement reform of hospitals through prospective payment and of physician fees through resource-based relative value scales, and most recently, practice guidelines to discourage unnecessary services. Individually, some of these strategies have worked to varying degrees, but none have succeeded in curbing the overall rise in health care spending.

This has led us to believe that there is no "magic bullet" to solve the problem of cost. Therefore, our efforts embrace a systemwide approach, involving many separate interventions.

ACCESS

Our experience with issues of health care access indicate that the barriers to care vary from locale to locale, region to region. While much needs to be done on the national scene, we have targeted a number of programs at the state level to help them provide timely, appropriate services.

Financial barriers are not the only impediments to equitable health care. Money alone cannot remove the barricades to access when services are either not available or poorly organized. One example is the persistent problem of maldistribution of physicians along geographic criteria. A 1989 survey of the nation's governors indicated that 48 states were experiencing severe shortages of primary care physicians, particularly in rural areas. Furthermore, this nation is facing a serious decline in the number of generalist physicians, in favor of those who choose to practice at the specialty or sub-specialty level. Generalist physicians, however, provide the first line of defense in primary and preventive care. Between 1965 and 1988, the proportion of generalist physicians declined from 43 to 30 percent of the physician population. A recent questionnaire of graduate medical seniors by the Association of American Medical Colleges indicates that this trend away from generalism is likely to continue. Thus, in sharp contrast to other developed countries, the United States faces a health care system where as few as a quarter of its physicians will be generalists.

Access is also blocked by attitudes. Many Americans are too suspicious and frightened to seek medical care, or are unaware when it is needed. For example, a recently published survey of prenatal care for the uninsured revealed that while financial problems were a consideration, they were closely followed by "ambivalent feelings," and the belief that prenatal care is not important. In 1988, 20 percent of white women and 40 percent of black women received no prenatal care in the first trimester of their pregnancy. If we are to combat our unacceptably high infant mortality rate,

we must find ways to get these women into prenatal care earlier in the course of their pregnancies.

CHRONIC ILLNESS

Contributing to the need for reform of the health care system is a financing system that places too much emphasis and funding on high-technology diagnostic and therapeutic services delivered in acute care hospitals, and too little money and energy in supportive care for those people with chronic health conditions. Health care trends indicate that an increasing number of medical conditions will be cared for outside the traditional hospital setting, in ambulatory settings and tertiary care facilities such as nursing homes. The current organization and financing of services at these sites works against compassionate, coordinated care.

Furthermore, the financing and organization of health programs tend to be categorical, and this limits and fragments the types and qualities of services to people in defined groups or specified settings. For each population there are separate providers, funding sources, and coordinating mechanisms. This has spawned redundant services, service gaps, and unnecessary obstacles to care.

Our experience with case management programs for the frail elderly, people with AIDS, homeless families, and individuals with chronic mental illness convinces us that many of the service requirements for these populations can be provided less expensively and more effectively outside the hospital setting. Furthermore, we have found that the service

requirements for many chronic ailments have striking similarities. Recently, we realigned our focus to address not merely the groups served, but the service system itself. We have targeted programs that will weave together such organizational and service delivery barriers as mental health services, personal assistance services, respite services for caregivers, transportation, and appropriate education and job training programs. A mixture of these services is imperative to the health and well-being of individuals with chronic illnesses or disabilities, and we are engaged in testing models that provide them at equal or even lower cost.

PREVENTION: THE PROBLEM OF SUBSTANCE ABUSE

As the nation's largest health care philanthropy, an important part of our mission is to identify persistent health problems. Today, the number one health problem confronting our nation is, clearly, substance abuse, specifically illegal drugs, and the use of tobacco and alcohol among our nation's youth. It is alarming to us that the widespread perception among the public is that the war on drugs has been won. Though it is gratifying to note the recent decline in the use of cocaine, 15 million Americans, most of them between 18 and 25 years old, are currently classified as drug users. Estimates of the number of infants who are born to crack-addicted mothers range from 1 in 100 to 1 in 25.

Furthermore, cigarette smoking was responsible for over 400,000 deaths in 1990, more than one-third of all deaths from major chronic diseases. Cigarette smoking during pregnancy accounts for 20 to 30 percent of low birth weight infants and about 10 percent of infant deaths. Twenty percent

of high school seniors smoke daily. In addition, alcohol abuse contributed in one year to some 95,000 deaths from disease, vehicle injuries, fires, homicides, and suicide. A third of all high school seniors report having five or more drinks in a row within the two weeks prior to being surveyed. And binge drinking on our college campuses is increasing at an alarming rate. The disparity between the severity of the social costs from substance abuse -- as measured by death, disability, and disruption -- and the relative inattention to this issue should give pause to all Americans.

Remarkably, for a problem so intransigent and widespread, we have a very poor knowledge base regarding substance abuse. One of our first tasks, therefore, is to better understand the causes of substance abuse: the role and interrelationships of individual factors that keep most people -- even those in high-risk environments -- from using harmful substances; the natural history of people who use substances for the first time; and the extent to which attitudes about substance abuse, particularly those among young people, can be influenced. We know precious little regarding the predictors of successful substance abuse treatment and recidivism. We will need to continue to develop and strengthen programs to prevent substance abuse and expand effective treatment strategies. Substance abuse may turn out to be the most stubborn, perplexing health care problem this nation has had to face in its history. It will take considerable courage and persistence to bestow upon successive generations of Americans a truly healthier future.

It is important to remember that in the early 1970s there emerged a

growing consensus among people involved in health care that some form of national health care was just around the corner. But the momentum was lost and the moment passed. The nation slid into a cycle of escalating costs and deteriorating services. Today, the momentum for fundamental change is on the rebound. There is once again a growing agreement, at least in principle, among health care payers, providers, legislators, and recipients that something needs to be done to rectify the system. It is our view that although the stage is set for reform, not all the players are in agreement as to how to enact it. One important contribution the foundation can make is to help the nation and its state and federal governments summon the will to face the strong and competing special interest groups of health care services, each of which is today convinced that reform of cost control should begin somewhere else.

Unquestionably, the health care delivery system in this country is deeply troubled. If the situation is allowed to deteriorate further, the cost of care will continue to climb unchecked, services will become even more disorganized and uncoordinated, and more Americans will be denied the basic right to affordable, compassionate and timely health care. Health care providers, who are at the heart of the health care delivery system, will be further crushed under the bureaucratic, oversight of cost-containment mechanisms, making them dispirited and disillusioned. We are already moving toward a health care system staffed by angry, cynical physicians. That prospect should frighten you as it does me. In addition, the present system of health care organization and finance will continue to transform the duty of providing compassionate care to our citizens into a business, in which

the ill and frail become nothing more than commodities. And, finally, our nation will fall even further behind other industrialized countries in the ability to provide basic health care to its citizens.

The consequences of a lack of reform go well beyond the health care arena, per se. They threaten to unravel the economic, cultural, social, and moral fabric of our society. As a nation, we must summon the collective conviction to right so abject a wrong as inadequate health care. Our nation has reached an impasse in which we literally can no longer afford to sit by and do nothing.

Medical science has made unparalleled strides during the past two decades. The potential for all Americans to contribute to society unimpeded by the specter of illness and disability is the greatest it ever has been. We remain dedicated to the idea that progress in scientific medicine must be matched by progress in the social institutions that deliver the benefits of that science.

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Mr. WAXMAN. Thank you very much, Mr. Schroeder.
Mr. Peevey.

STATEMENT OF MICHAEL R. PEEVEY

Mr. PEEVEY. Mr. Chairman, members of the committee, my name is Michael Peevey. I am president of Southern California Edison Co., and I am accompanied here today by Dr. Jacque Sokolov, our vice president and medical director.

Southern California Edison is the Nation's second largest electric utility. We provide service to about 10 million people in a 50,000 square mile service territory in central and southern California. We are involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members. We operate eight primary care clinics, two first-aid stations, and a large corporate pharmacy in house, and self-fund and self-administer our own health plans, including the processing of all medical claims.

I am here today because, despite Edison's successes in controlling our health care costs, we believe there needs to be a Federal response to the problem of rising national health expenditures.

The decade of the 1980's was a period of very rapid growth in health care costs for Edison. In just 10 years, our annual spending on health care quadrupled, rising from \$21 million in 1980 to \$88 million in 1990. By the late 1980's, our costs were rising at an average rate of 23 percent a year, a rate that could have affected our competitive position in an increasingly deregulated utility industry.

We responded in 1989 with a series of innovative health care management strategies that have reduced our annual growth rate to about 10 to 12 percent a year. Through these strategies we have created an organized system of care that contracts with selected providers, encourages participants to take an active role in managing both their own health and health treatment, and monitors and manages the delivery of care. It combines financial incentives for employees with active management to encourage the efficient use of care.

First, our indemnity plan, which we call HealthFlex, is designed to encourage employees to select lower cost options and contribute the saved employer contribution plus their own fund to a flexible spending account to pay out-of-pocket expenses.

We have also established a self-funded HMO that gives employees another lower cost option while creating a broader pool over which to distribute health care experience. Nearly 90 percent of our employees have now enrolled in one of our lower cost alternatives, for a savings of \$14 million in 1989 and 1990.

Second, we have established our own preferred provider network of 7,500 physicians and 85 hospitals and encouraged participants to use the network through reduced copayments. Three-quarters of our health plan dollars are now going to network providers. This, coupled with active management of health care services and the phase-in of similar managed care features for our retirees, has helped us save \$24 million in 1989 and 1990.

Third, our preventative health care account and good health rebate provide financial incentives for employees and spouses to

use preventative services and reduce their health risks. We have already screened 45 percent of eligible plan participants for the good health rebate program.

The organized care system we have created works to encourage a more efficient use of medical services by our employees. Nonetheless, our health care costs continue to be driven up by forces beyond our reach. Hospitals maintain excess bed capacity and continue adding new units and equipment.

When we negotiate reduced rates, hospitals raise their charges to other patients to maintain the same revenue stream. New specialist physicians continue to saturate our area, and the incidence of expensive specialty procedures simply rises without constraint. Expensive new diagnostic technology is introduced and quickly spreads through ambulatory clinics and physicians' offices where it adds to, instead of replacing, the use of earlier technology. It is as if we had stepped, with Alice, through the looking glass and the rules of economics all work in reverse.

The last decade of health care competition has driven prices, utilization, and provider income up, not down. It is the economics of a market with unlimited resources. Nothing we can do as an individual buyer is going to make much difference. To manage system-wide costs, the private and public sectors will have to work as a team with Federal policy focused on these external factors.

Edison has thought through and provided concrete proposals for Federal action to control health care costs in the past. We have included several suggestions in our written testimony for this hearing. We are ready, however, to support almost any credible approach that can achieve the objective of controlling health care costs.

What we mean by controlling costs is a slower rate of growth in national health care expenditures. Expenditures are now growing at more than twice the rate of inflation, and business costs are growing twice as fast as expenditures. We believe it is reasonable to end cost shifting and bring employers' cost increases in line with the general rate of expenditure growth. Beyond that, we believe that the Nation can achieve an expenditure growth rate that is lower than the current rate and, more importantly, steady and predictable.

The problem is not finding the right solution, the problem is finding the will to enact any solution. Twenty-five years of complicated debates among the experts have becalmed health care policy in a Saragasso Sea of competing economic theories and reform proposals. There is growing impatience with this inaction, as was indicated this morning.

A poll by the Wall Street Journal and NBC News conducted by the President's pollster Robert Teeter and Democratic pollster Peter Hart, and published just a little over a week ago, showed what I think is a surprising turnabout in public opinion about health care. Forty percent of the registered voters they surveyed are now saying that health care is the Nation's first or second most important domestic problem. The majority of voters is saying the problem is high costs, and, surprisingly, over half are saying it is primarily the Federal Government's responsibility to fix it. We agree with these voters.

In addition, we believe many of our colleagues in business and many other interest groups who have fought reform in the past may now be closer to making concessions in order to achieve important health care objectives. Everyone will have to concede something if we are to have reform. Doctors and hospitals will have to concede on cost containment if we are to have universal health care coverage. Employers will have to concede on mandatory coverage if they are to get health care cost containment. Insurers will have to concede on insurance market reform and lower administrative costs. Organized labor and consumers will have to concede on some forms of cost sharing. Congress will have to concede on fair Medicaid payments and the taxes to pay for them.

While these agreements get worked out, a number of basic tools for improved management fundamental to any reform approach should be enacted. Six building blocks for comprehensive reform that we think could be enacted this year include a standing national council on health care, a uniform national claims form, a national claims data base, a data base on capital purchases, a national technology assessment agency, and Federal statutory support for State and local efforts to end cost shifting.

Without substantial cost containment, Edison's health care budget will, in a decade, be nearly triple what it is today, and we won't be, by any means, the worst case. We are ready to work with you to bring about reform. What we need most from the government is the leadership to forge a consensus and chart a clear course for the future.

Thank you.

[The prepared statement of Mr. Peevey follows:]

STATEMENT OF MICHAEL R. PEEVEY, PRESIDENT
SOUTHERN CALIFORNIA EDISON COMPANY

Mr. Chairman and Members of the Committee:

My name is Michael Peevey. I am president of the Southern California Edison Company and I am accompanied today by Dr. Jacques Sokolov, our vice president and medical director. Southern California Edison is the nation's second-largest electric utility, providing service to ten million people in a 50,000-square-mile territory in Central and Southern California.

I appreciate the opportunity to testify today on the critical need for reform of our nation's health care system. Edison is heavily involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members. Since 1903 we have operated primary health care services in-house, which today include eight primary care clinics, two first-aid stations, and a large corporate pharmacy. In 1990, there were more than 100,000 patient visits in our clinics and 250,000 prescriptions processed in our pharmacy. We also self-fund and self-administer our own health plans, including the processing of all medical claims.

I am here today to ask for your help in developing a federal policy aimed at managing the growth in national health care spending. As a member of the National Leadership Coalition for Health Care Reform, the Washington Business Group on Health, and the Alliance of Business for Cost Containment, Edison is working actively to encourage a federal response to the issue of escalating health care costs. While you may expect a corporation to be motivated to advocate national reform by a failure to control its own costs, Edison's position evolves from our success in managing our health care costs, and the understanding we have gained of the need for national reform.

Edison's Cost Management Experience

The decade of the 1980s was a period of very rapid growth in health care costs for Edison as well as for other employers. In just ten years, our annual spending on health care quadrupled -- rising from \$21 million per year in 1981 to \$88 million per year in 1990. By the late 1980s our costs were rising at an average rate of 23 percent a year. At that rate of increase, health care costs would have begun to affect Edison's competitive position in an increasingly deregulated utility industry. In 1989, we responded with a major effort to restructure our health care plans.

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Our reform was aimed at encouraging our employees to take more responsibility for their health, developing financial incentives for the use of efficient, high quality providers, and managing utilization to minimize unnecessary, inappropriate and harmful health care. That approach has worked very well for us -- our long term annual growth rate has now been reduced from 23 percent to about 10-12 percent. Let me detail the components of our reform.

Incentives for Efficient Use of Care

First, we created financial incentives for participants to realistically evaluate their health plan needs and to use health care more efficiently. We have done this through a combination of new options which include our indemnity plan called HealthFlex, a self-funded HMO and health care reimbursement accounts.

HealthFlex offers a choice of three deductible options and minimizes copayments for employees who use our preferred-provided network. For employees who prefer an HMO alternative, our self-funded HMO option provides that delivery alternative while allowing us to include this experience in our health care group insurance risk pool. Employees may now elect to put pre-tax funds in a flexible spending account, which they can use to pay deductibles, copayments or other out-of-pocket portions of their health care bills. This creates new alternatives for employees when considering how to manage their own health care costs. For example, they might select a "rich" option where contributions are required or select a higher deductible option with a lower cost -- and cover the out-of-pocket expense through their reimbursement account.

A large proportion of our employees have responded to these incentives. To date, 87 percent of Edison employees have enrolled in one of our lower-cost alternatives -- either the healthFlex options (74 percent of employees), or our self-funded HMO option (13 percent of employees). Due to the changes in incentives for employees making health plan selections, we have realigned the risks assumed by the various options and created a more equal distribution of health plan experience. These changes saved \$14 million in 1989 and 1990 over the anticipated expenditures.

Management of Health Care Utilization

Second, we focused our utilization management efforts on helping participants get necessary and appropriate care in several key areas: hospitalization, outpatient surgery, mental health services and substance abuse treatments.

This works in tandem with our preferred provider network of 7500 physicians & 85 hospitals which we have built by credentialing and monitoring providers to identify those best able to deliver quality services at pre-set rates. We also initiated a five-year effort to phase in managed care and cost sharing features for future retirees. We implemented an active management of our inpatient admissions and outpatient services, with financial incentives to direct plan members to our selected preferred providers for a savings of \$24 million over our expected costs for 1989 and 1990.

Incentives to Reduce Health Risks

Third, we created financial incentives to encourage our employees and their spouses to reduce their own health risks. We use two financial incentives: a Preventive Health Account that provides \$100 toward the use of preventive services, and a Good Health Rebate that provides cash incentives for participants who are within screening guidelines for 5 cardiovascular risk factors or who undertake a program to reduce any elevated risk factors. This program has worked well to date -- although it is entirely voluntary, we annually screen more than 45 percent of eligible plan participants for the Good Health Rebate. The gains in health for our employees and the savings for our health plans will come in the future.

Results

In short, at Edison, we set out to involve our employees in the management of our health care costs -- and our efforts are paying off. In a two year period - 1989 and 1990 - we spent approximately \$38 million (or 20 percent) less than if we had not implemented these programs. We achieved a high rate of screening, counseling, and behavior change in our preventive health efforts.

What we have set up is an organized system of care for our employees. We have contracted with selected providers to deliver quality services at reasonable prices. We have encouraged our employees to take an active role in managing both their own health and health care treatment through a series of financial incentives. We have measured, monitored, and managed the delivery of care in order to enhance our ability to improve the quality of care without raising the price.

Our system of managing care could be a valuable resource for other employers in Southern California who may wish to join us in using our coordinated approach. These

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kinds of multi-employer consortiums for negotiating payment rates and managing utilization should be a starting point for all of our efforts to control health care spending. Ultimately, every employer should be able to join an organized system of health care delivery with appropriate financial incentives for both providers and patients to encourage the efficient use of health care services.

Nevertheless, we still are dealing with only one aspect of the broader cost-containment problem -- creating incentives for efficient utilization of health services. As long as our fragmented system of paying for care continues, the other factors contributing to rising health care costs -- the proliferation of technology and capital, the oversupply of specialists, the increasing costs of medical malpractice liability -- will continue to be beyond any single corporation's control.

A Dangerous Burden for Business

Since the enactment of Medicare, this nation has had a consistent pattern of shifting the burden of financing health care from government and individuals to business. The share of national health expenditures paid by business has risen from 19 percent in 1967 to 30 percent today. Health care that twenty years ago equaled eight percent of average corporate pre-tax profits, has become equal to half of corporate pre-tax profits and all of their after-tax profits.

This increase in burden, projected over the next decade or two, cannot be sustained by American business. While Edison has brought its long-run annual health care cost increases down from 23 percent to 10 to 12 percent, we are still experiencing a growth rate that will triple our costs every 10 years. As American businesses find themselves under increasing pressure to compete at home and abroad, our ability to respond is slowed by the disproportionate escalation in labor costs.

Businesses are hampered not just by the rate of growth but by the unpredictability of that rate. Corporations will soon be required under the new Financial Accounting Standards Board (FASB) accounting standards to account for their estimated liabilities for all future retiree health care to be provided to today's workers as much as a half a century from now. Our expectations about future health care costs must now become a very real part of our current ability to attract investment capital. All of us, government, business and individuals, have to assume that something will happen soon to break this upward spiral of health care expenditures. But it will not happen if we merely wish for it. We must act now to make it happen.

Edison's Proposal for Federal Action

Managing systemwide health care costs is more than any corporation can do individually -- it requires a partnership between the private and public sectors. Edison is committed to providing health care to its employees and managing their utilization of health services. From the federal government we need greater control over the external factors that raise our health care costs. We need to know that our cost increases will be predictable and that greater-dollar expenditures are buying better care.

An End to Cost Shifting

The first thing we would like to see is an end to cost shifting. Medicaid cuts, the growth in uncompensated care and even our own negotiated discounts are forcing providers to dramatically increase charges to other third-party payors. Cost shifting is a major factor accelerating small employers' costs. Cost shifting also contributes to general inflation when uncertainty about payment forces providers to anticipate and overadjust charges.

At the root of cost shifting are inadequate Medicare and Medicaid payments. The dilemma for the Congress is that to pay fairly for Medicaid and Medicare beneficiaries additional revenue will be required. Edison would rather pay health care costs for the poor and elderly through broad-based and equitable taxes than through the hidden charges we now have in our health plans.

Merely paying more to providers who serve government beneficiaries will not by itself improve the stability of health care financing. Edison believes that the federal government should create a system of all-payor rate negotiation to ensure that every health care payor, no matter how small, can benefit from the rates negotiated by the largest purchasers. An all-payor approach is at least one way to ensure that no one payor can control its costs merely by dumping its expenses in other payors' laps.

A Limit on National Expenditures

While uniform rates may eliminate inequities and stabilize financing, they do not prevent excessive utilization of health services from driving-up national expenditures. To develop certainty and predictability in health care financing, Edison believes an overall limit should be set on increases in total expenditures -- a national expenditure target. A national target will give us all a yardstick for measuring our progress toward cost

containment, and it will provide some modest assurance to employers that there is some limit to their health care spending.

A Rational Allocation of Resources

In the end, however, much of this effort will be futile unless we also constrain the endlessly increasing supply of health care. In most industries, increasing supply tends to reduce prices -- in health care the opposite is true. Hospital profits rose in the 1980s while an increasing proportion of hospital beds were empty. An oversupply of physicians, predicted to lower physician incomes in the eighties, instead produced more services. An explosion in new diagnostic technologies added hosts of new medical procedures rather than replacing older, less efficient, methods.

While the Health Care Financing Administration's efforts to limit excessive Medicare payments for new capital and technology are to be applauded, they should not be confined to the government. All payors need to be represented in the effort to reduce excess hospital capacity and efficiently allocate new technology, if these efforts are to be truly effective.

Greater Value from Health Care Spending

Finally, we need to be assured that we are getting a dollar's worth of health care for a dollar's worth of cost. Edison is willing to manage its health programs to avoid unnecessary and inappropriate care and encourage the highest quality of medical care. We need the leadership of the federal government to generously fund outcomes research, encourage the development of medical practice standards, and ensure that payors remain free to identify, contract with, and reward providers who can deliver appropriate, high quality medical care.

Begin with the Building Blocks

The prospect of another decade of rapid acceleration in health care costs is not a cheerful one for the business community. Yet, it is unlikely that Congress can act quickly on comprehensive reform, and even if it could, initiatives begun today would have little chance of slowing the growth in expenditures for several years.

While a comprehensive program to control health care spending cannot be developed overnight -- it is important to make a start; and I believe no matter which reform

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approach you prefer, all reforms will have to start at pretty much the same place. To become knowledgeable purchasers at the local level or the federal level, as individual payors or as part of an all-payor system, we will have the same need for information. For this reason, Edison recommends six "building blocks" of federal policy that should be laid as a foundation for comprehensive reform. They are:

- 1) A National Council on Health Care that would monitor national and state-level health care expenditures, propose non-enforceable expenditure targets, and report annually to the Congress on causes of expenditure growth and proposed solutions;
- 2) A single national health care claim form that would be used by all third-party payors, could be entered into an electronic claims system, and could generate statistical records for a national health care data base;
- 3) A national data base of significant provider capital purchases to support statistics on the allocation of new capital and technology;
- 4) A national technology assessment agency with responsibility for determining the efficacy of new procedures and equipment, and publishing coverage guidelines for payors;
- 5) Medicare/Medicaid waivers to permit states to adopt all-payor systems, with a multiyear transition and additional federal financial support to adjust government payments to private-sector payor rates; and
- 6) Waivers of federal antitrust restrictions on community multipayor consortiums to permit group negotiations with physician and hospital groups.

We believe these "building blocks" could be implemented without great expense, and would lay the foundation for developing the comprehensive reform we hope will follow.

Comprehensive Reform Bills

Edison is particularly pleased that the Congress has in the last two months begun incorporating cost containment proposals in legislation to reform the health care system. The Chairman's bill to enact the Pepper Commission recommendations (H.R.2535), introduced in the Senate by

Senator Rockefeller (S.1177), and the Senate's HealthAmerica bill (S.1227), introduced by Senator Mitchell both introduce cost containment concepts that have not appeared in earlier legislation. We believe these bills will help broaden the debate from simply expanding health insurance coverage to expanding coverage and controlling costs.

Both bills (H.R.2535/S.1177 and S.1227) provide a framework for reform which we support. The elements listed below, and contained in both bills, are approaches we favor. They:

- build upon the existing employer-based health insurance system,
- aim for universal access,
- provide a minimum standard for health benefits that would override state benefit mandates,
- expand health insurance for the poor and improve government program payments to providers,
- improve the availability and affordability of health insurance for small employers,
- encourage the use of managed care, and
- provide opportunities to develop greater uniformity in provider payment rates.

We feel that HealthAmerica (S.1227) establishes a more complete cost containment mechanism than the Pepper Commission proposal (H.R.2535) envisions. In fact, HealthAmerica embodies many of the cost containment approaches we have supported in the past -- a number of the "building blocks" we discussed earlier and a structure for expenditure targets and negotiated uniform payment rates. While we are not convinced the specific mechanisms used in the HealthAmerica proposal would be effective in controlling costs, we are pleased that the proposal has brought together the concepts of a national expenditure board, expenditure targets, all-payor rate negotiation, national technology assessment, and managed care and initiated a serious debate on how to control health care costs.

These bills are an important step in advancing the cost containment debate, but they reflect the fact that we are still a long way from a consensus on the appropriate cost containment mechanisms. We look forward to working with this Committee as it refines these proposals to

reflect the thoughts and concerns of business and other groups with vital interests in health care reform.

Conclusion

In conclusion, I am personally concerned with the vision I have of our company health care program a decade from now. By then, at our current long-term growth rate, Edison's health care budget will have nearly tripled. While we certainly plan to continue providing excellent health care benefits to our employees in the next century, we have no desire to become a health care company in the process.

We have worked to manage our costs, but much of the current increase in our costs is the result of forces beyond our control. It will take action by the federal government to begin to manage national health care expenditures.

This is not only the approach we prefer, we believe public sentiment is shifting quickly in this direction. The surprising results of a poll by the Wall Street Journal and NBC News, which were reported by the Journal on June 28th ("Voters, Sick of the Current Health-Care System, Want Federal Government to Prescribe Remedy" p. A14), indicate that health care cost containment has now emerged as one of the top domestic issues for registered voters. The poll, conducted by Robert Teeter, the President's pollster, and Peter Hart, a Democratic pollster, found that 40 percent of the registered voters now view health care as the number one or number two domestic issue. The majority of respondents (55 percent) believe the high cost of health care is the leading problem (followed by 32 percent who feel it is access) and more than half believe the federal government has the primary responsibility for solving the cost problem.

We believe Americans are ready for a national solution to this problem, and we are ready to work with you to bring about substantial reform. What we need most from the federal government today is the courage to set a clear course for the future; a future that will bring about predictability and manageability, and help us work together to ensure the good health of our nation.

Mr. WAXMAN. Thank you very much.
Mr. Sullivan.

STATEMENT OF SEAN SULLIVAN

Mr. SULLIVAN. Mr. Chairman, members of the subcommittee, I am Sean Sullivan, vice president of New Directions for Policy, a Washington-based public policy research and consulting firm specializing in health care issues. We have a national client base and are working with purchasers and providers across the United States to improve the financing and delivery of health care.

I appreciate this opportunity to testify on current initiatives to change the way that health care services are provided and paid for in the private sector, initiatives that are commonly referred to as managed care. As the Congress and the Nation engage in the serious debate over how to reform the financing and delivery of services, that debate must be fully informed about changes already taking place within the health care system, changes initiated by private purchasers of care such as those I will be describing.

The leading practitioners of managed care view it as more than just another effort to contain rising health care costs. They see it as a fundamental change in the way health care is purchased and delivered based on the new relationship between purchasers and providers of care. Smart purchasers are no longer just looking for discounts, they are seeking value or good quality at a reasonable cost. Quality and value are becoming the measures of performance in health care, just as they are in all other sectors of the economy.

Quality is not only good in itself, it is one of the keys to controlling costs. The potential significance of this truth is suggested by the experience of the Honeywell Corp. in a controlled experiment with the Mayo Clinic, an acknowledged provider of high-quality health care. Using data adjusted to show what the use of medical services would have been if Honeywell employees with similar characteristics to Mayo patients had been treated there, the results were startling. Honeywell's costs would have been lower by a third. This discovery is leading the company to contract with exclusive provider organizations built around group practices. Honeywell believes these closed systems are superior to looser provider arrangements because physicians in a group practice exercise informal quality control over each other through peer pressure.

Blue Cross-Blue Shield of Minnesota has initiated several innovative managed care programs to get a better understanding of factors related to quality. The first is appropriateness, the need to perform the service and the best way for doing it. The second is effectiveness, the outcome for and the benefit to the patient. The third is efficiency, the best use of medical resources.

The Value Health Sciences Program evaluates whether specific procedures are medically appropriate by comparing proposed treatments with clearly defined appropriateness criteria for 14 inpatient and outpatient procedures. These criteria were developed from a 6-year Rand Corp. study and thousands of diagnoses, treatments, and outcomes. Blue Cross-Blue Shield instituted the program after finding wide variations in procedure rates among hospitals, fivefold to tenfold differences, for example, in tonsillectomies and Cesarean

sections. Its aim is to determine whether proposed procedures are appropriate in a given case.

Cleveland Health Quality Choice is the largest and most ambitious joint venture between purchasers and providers in the Nation. Companies that provide benefits to more than 350,000 people, an association representing 60 hospitals, and an organization of 4,000 physicians are working together to establish a common set of quality measures for selected procedures that seem to be performed too often, such as Caesarean sections and hysterectomies.

Outcome indicators will include rates of mortality of hospital-acquired infection and of unplanned readmissions or returns to surgery within 30 days of discharge, and a customized risk adjustment methodology is being developed to aid accurate comparisons of providers.

When all the pieces are in place and tested, Cleveland will have a community-based system for measuring and improving the quality of care being provided. Concurrently, employers' benefit plans are being redesigned to give workers strong financial incentives to use the high-quality, cost-effective services identified by the measurement process.

Similar initiatives to develop quality-based purchasing and delivery systems for entire communities have been launched in Milwaukee, Seattle, and Denver, with other cities not far behind. Companies, such as Allied Signal, Xerox, Chevron, and Southwestern Bell are already using financial incentives to steer their employees to networks of providers selected and managed by third party contractors. Employees are offered the equivalent of first dollar coverage to stay within the network. They may go outside but incur heavy cost sharing if they do. These incentives are essential for rewarding superior providers with more patients. The few but growing number of companies using this approach have reduced the rate of increase in their health care costs by as much as 50 percent.

Emphasis on quality is the key to controlling costs through shifting from external quality control—looking over doctors' shoulders at everything they do—to dealing with providers who have their own builtin processes to constantly improve their own quality from the inside out.

Mr. WAXMAN. Mr. Sullivan, the rest of that statement is going to be in the record. I am going to now recognize members for questions.

Mr. SULLIVAN. Okay.

[The prepared statement of Mr. Sullivan follows:]

STATEMENT OF SEAN SULLIVAN, VICE PRESIDENT NEW DIRECTIONS FOR POLICY

I am Sean Sullivan, vice president of New Directions for Policy, a Washington-based public policy research and consulting firm specializing in health care issues. New Directions has a national client base, and is working with purchasers and providers across the United States to improve the financing and delivery of health care. I appreciate this opportunity to testify on current initiatives to change the way that health care services are provided and paid for in the private sector -- initiatives that are commonly referred to as "managed care."

I commend the Subcommittee for holding this hearing to look more closely at the problems of health care costs and access to services, and to consider where present efforts to control costs and expand access are leading. As the Congress and the nation engage in a serious debate over how to reform the financing and delivery of services, that debate must be fully informed about changes already taking place within the health care system -- changes initiated by private purchasers of care such as those I will be describing.

Defining Managed Care

The leading practitioners of managed care view it as more than just another effort to contain rising health care costs; they see it as a fundamental change in the way health care is purchased and delivered, based on a new relationship between purchasers and providers of care. Smart purchasers are no longer just looking for discounts; they are seeking value -- or high quality at a reasonable cost. Quality and value are becoming the measures of performance in health care, just as they are in all other sectors of the economy.

Quality and Cost

Quality is not only good in itself, but is one of the keys to controlling costs. The potential significance of this truth is suggested by the experience of the Honeywell corporation in a controlled experiment with the Mayo Clinic, an acknowledged provider of high-quality health care. Using data adjusted to show what the use of medical services would have been if Honeywell employees with similar characteristics to Mayo patients had been treated there, the results were startling: Honeywell's costs would have been lower by a third.

This discovery is leading the company to contract with exclusive provider organizations built around group practices, such as the Park-Nicollet Clinic in Minneapolis. Honeywell believes these closed systems are superior to looser provider arrangements like independent practice associations, because physicians in a group practice exercise informal quality control over each other through peer pressure.

Measuring Quality

Blue Cross Blue Shield of Minnesota has initiated several innovative managed care programs to improve quality and control costs by getting a better understanding of several factors related to quality: (1) appropriateness -- the need to perform the service and the best way for doing so; (2) effectiveness -- the outcome for, and benefit to, the patient; and (3) efficiency -- the best use of medical resources.

The Value Health Sciences program evaluates whether specific procedures are medically appropriate by comparing proposed treatments with clearly defined appropriateness criteria for 14 inpatient and outpatient procedures. These criteria were developed from a six-year RAND Corporation study of thousands of diagnoses, treatments, and outcomes. Blue Cross Blue Shield instituted the program after finding wide variations in procedure rates among hospitals, for example, five to tenfold differences for tonsillectomies and Caesarean sections. Its aim is to determine whether proposed procedures are appropriate in each given case.

Blue Cross Blue Shield is also using the MedisGroups program to adjust for the severity of illness in comparing hospital admission patterns and outcomes. Severity ratings are assigned to patients after evaluating clinical findings taken from their abstracts after admission. These ratings are then used to identify questionable admissions patterns and negative outcomes for patients with less severe conditions.

Community-Wide Quality-Based Purchasing

Cleveland Health Quality Choice is the largest and most ambitious joint venture between purchasers and providers in the nation. Companies that provide health benefits to more than 350,000 workers and their dependents, an association representing 60 area hospitals, and an organization with 4000 physician members are working together to establish a common set of quality measures for selected procedures that seem to be performed too often -- such as Caesarean sections and hysterectomies. Outcome indicators will include rates of mortality, of hospital-acquired infection, and of unplanned readmissions or returns to surgery within 30 days of discharge. And a customized risk-adjustment methodology is being developed to aid accurate comparisons of providers.

When all the pieces are in place and tested, Cleveland will have a community-based system for measuring and improving the quality of care being provided. Concurrently, employers' benefit plans are being redesigned to give workers strong financial incentives to use the high-quality, cost-effective services identified by the measurement process. Similar initiatives to develop quality-based purchasing and delivery systems for entire communities have been launched in Milwaukee, Seattle, and Denver -- with others not far behind.

Importance of Incentives

Companies such as Allied-Signal, Xerox, Chevron, and Southwestern Bell are already using powerful financial incentives to steer their employees to networks of providers selected and managed by third-party contractors. Employees are offered what is essentially first-dollar coverage to stay within the network; they remain free to go outside, but incur heavy cost-sharing if they do. Purchasers regard these incentives as essential for rewarding superior providers with more patients. The still small but growing number of companies using this approach have reduced the rate of increase in their health care costs by as much as 50 percent.

Continuous Quality Improvement

Emphasis on quality as the key to controlling costs is gradually shifting from external quality control -- looking over doctors' shoulders to check everything they do -- to dealing with providers who have built-in processes to constantly improve their own quality from the "inside out." Attempts to monitor quality are leading more companies to conclude that quality improvement comes from identifying the common causes of most problems, which are in the system, and controlling them on the basis of statistical procedures. This is the approach popularized by industrial quality experts and adopted increasingly by American business.

The approach has several principles: (1) quality improvement and innovation are a continuous process rather than an occasional "fix"; (2) statistical process controls are superior to "inspection for defects" as a technique for ensuring quality; and (3) everyone in an organization must be involved in quality management. More companies like Honeywell believe these principles of quality control can be transferred successfully from industrial management to health care, with beneficial effects on costs as well. But they have important implications for the organization of health care delivery, because they are best applied in group practice settings.

In Sum

The new managed care movement goes far beyond the price discounting that has characterized so many preferred provider organizations to date. With its emphasis on the quality and value of medical services, managed care seeks to change the system from within by judging and rewarding providers on the basis of their performance. If adopted by all purchasers including government, it would result in a health care system that delivers value, a system driven by quality instead of price.

The kind of managed care I have been describing today will not -- indeed, cannot -- sweep the nation overnight. It must be developed carefully, ideally as a cooperative effort among purchasers, providers, insurers, and government -- which must both adopt it as a purchaser and remove public policy barriers to its spread, i.e., anti-managed-care laws springing up in some states. But it has the potential to radically reform the delivery of health care from within the system, which will also prove the best route to controlling costs.

Mr. WAXMAN. I want to start off with Mr. Peevey.

Mr. Peevey, you have outlined the success of Southern California Edison in holding down costs by moving to a managed care kind of situation. Your company has been able to contain the cost of coverage, and you have 55,000 employees. How feasible would it be for small employers to do the same thing that you are doing—let's say a small employer that has, let's say, 25 employees? What are their chances of limiting health care cost increases to 10 to 12 percent per year as you have been able to do?

Mr. PEEVEY. Candidly, I think it is slim to none. I mean you have to first begin with the recognition that, as the previous speaker from CBO indicated, only 39 percent of the businesses in the United States with 25 or fewer employees have any kind of health care, so you don't even have that.

The only way that employers could do what Edison has done would be to act in some collective fashion, in some cooperative fashion, banding together, which I think is reasonably unlikely to see occur.

Mr. WAXMAN. I am struck by your call for Federal as opposed to State action to help control health care costs. Some people have said the States and not the Federal Government should take the lead in this reform. From your point of view, as the president of a large corporation, what are the advantages of Federal intervention, and why would you object to the State taking—

Mr. PEEVEY. I don't object to the State taking some role, but, in all candor, the State that Southern California Edison is headquartered in and you represent has severe financial problems of its own. We are now in the second week of the new budget year without a State budget, as you know. So the difficulties are very severe at the State level.

But perhaps more importantly, the health care problem is a national problem, and on the Medicare/Medicaid problem of cost shifting, the Federal Government plays an incredibly important role, so we think that the focus really can be here in the areas that I outlined.

Mr. WAXMAN. You indicated in your testimony that we need an end to cost shifting by the public programs including Medicaid, and you note that shifting is a major factor in increasing small employers' costs. Can you give any estimate of how much your costs have increased as a result of MediCal, which is the California Medicaid program, underpaying hospitals and physicians in California? I assume that the cost shifting burden is larger for small employers in Southern California than for larger employers like yourself. Do you have any idea how much larger?

Mr. PEEVEY. Well, there are two questions there. Regarding us, our best estimates—and I could provide you with perhaps more detail later, but our best estimates are that the consequences of MediCal/Medicare and the uninsured is a cost shift to us of about 20 percent, or more.

Obviously, it is going to be greater for small employers who have health care coverage, because they don't have the marketability we have to go out and have our own network of doctors and hospitals and so forth and set our own reasonable payment amount. The

small employer just can't afford administratively to do those kinds of things. It is just that simple.

Mr. WAXMAN. So if we do nothing, if we follow the administration's position of not coming up with any change or reform in our health care system, obviously this cost shifting will continue. Do you think it will get worse? And what are the implications for large and small employers and for the workforce?

Mr. PEEVEY. Number one, it will get worse.

Number two, a significant number of people that have Cadillacs will end up driving Fords, and those that are driving Fords will be taking Shea's mare. I mean that is about the way—it is going to get worse and worse and worse in terms of the costs here, and employers and others will continually try to find ways to shift the cost to an ever smaller segment of people that will pay, and I see an ever descending spiral of difficulty for the society as a whole here without some action.

Mr. WAXMAN. Dr. Schroeder, Dr. Reischauer just testified, and I think you were here for his testimony, and he seemed to be saying our cost control efforts are not successful enough, and therefore if we are going to extend coverage to more people, we had better learn to control costs. Yet he also seemed to be saying—and I am interested in looking at his report on Medicare—if we took the Medicare benefit package and had everybody just get that package and the Federal Government paid for it, there would be enough cost savings, presumably from overhead, in order to pay for everybody to get a Medicare package. What do you think of that? Do you think that possible?

Mr. SCHROEDER. I think there is a big shift from saying what the package is to what people get, and that is, I think, where insufficient attention has been paid—that is, to the health care delivery system. I don't think cost containment is just a financing question, and I think until there is control, or better control, of supply of physicians, the type of physicians, the kind of technology, and how those are priced, the capacity of that system to absorb costs is almost infinite. So I think it would depend on the presumptions as to how the health care was shaped.

But I am quite confident that if you just shifted how people were being paid for without making any changes in the rules or how the health care delivery system worked, we would be going up 12, 14, 15, 16 percent within the next 2 or 3 years.

Mr. WAXMAN. I presume that he is thinking along the lines of taking the Medicare program and taking the reimbursement rates under that program with the limitations of the DRG and the physician payment system.

Mr. SCHROEDER. If there are no further cost containment mechanisms, I suspect that in the first year there might be an equivalency, but over time you just go back on that same spiral.

Mr. WAXMAN. Mr. McMillan.

Mr. McMILLAN. Just to carry that on a little further, Mr. Schroeder, if that is all you do, and don't address the things that are driving those costs up, then basically what you would end up with, wouldn't you, if you have obligated yourself to provide that to the population as a whole and set a revenue generation scheme—I don't know what that would be or what he proposes—then your al-

ternatives are going to be exercise control as well as reimbursement, to stay within a certain cost structure, and that puts the government in the position of defining what is appropriate care. I mean isn't that a logical outcome of that?

Mr. SCHROEDER. Government is doing that now with its PRO's, and I think there is evidence in the literature, and many experts would say that under the existing health care benefits package for Medicare we are doing much too much care in some instances, and the savings for that, I think, could be used to provide benefits for those that don't have it. The question that you have hit on—how do you get those savings?—could be done in a number of different ways, and we have not been very successful.

Mr. McMILLAN. I don't want to get back into those that we discussed previously, but there are a lot of things that government could insist on if it chose to. I mean it could address the question of defensive health care costs, which we haven't, as a part of the way it exercises that control. I mean I think we need to spend a lot of time trying to define that and face up to it.

Mr. Peevey, you are running—I don't know whether you are running the best corporate plan or not, but it sounds like a good one. Have you compared the administrative costs of that as a percentage of total cost in contrast to what you think a federally run substitution for it might be, or what do you think would happen to your system alongside a federally run system? Would it save you anything, or would perhaps you end up under what Mr. Reischauer will propose having to generate the same revenue, turn them over to the government, and receive a letter reimbursement?

Mr. PEEVEY. Candidly—and I think what Mr. Reischauer is laying out for you is a range of choices for you to ponder—I didn't get the sentiment that he was light on any particular one. But we feel strongly that, to a large extent, the employer-based system that we have in this country and we have at Edison, and we worked hard to develop, we would like to see that maintained in a health care reform system. In other words, we would like to build on the existing system, to have universal access, to extend programs to others, but we don't want to see what we have today all topple.

Mr. McMILLAN. One of the things the Canadians did was say, "We are not going to have a two-tiered system; if we do this thing on a national basis, then everybody is going to get the same treatment."

Mr. PEEVEY. I understand that. I am not here to endorse the Canadian system.

Mr. McMILLAN. But you did say that you thought there should be a greater Federal role.

Mr. PEEVEY. A greater Federal role, because, among other things, the Medicare and Medicaid programs are very significant programs that involve significant amounts of cost shifting, and we end up getting some of those costs shifted to us despite our best efforts to manage our own care in the most logical and effective and efficient way we can, and yet we have one-sixth of the Nation going without health care. It cries out for remedy.

Mr. McMILLAN. I don't disagree with that.

Mr. PEEVEY. I know you don't. But this is a very contentious issue, obviously, and opinions markedly differ around this town alone, let alone all across the United States. That is why I proposed six building blocks that people could agree on and could move on this year while some of these other things perhaps get some more airing for a while.

I mean I would like to see movement faster than maybe some others in the employer community, but we all have to read the tea leaves and see what is reasonable here in terms of achievement.

Mr. McMILLAN. I think what you say is true. I mean I have got employers that run good plans in my district who are getting fed up, and their attitudes have changed enormously on this issue.

Mr. PEEVEY. In southern California, for example, half the trauma centers have been closed in the last 18 months. It is a myth to think that people who have severe problems don't get health care; they get health care in some form, maybe not as good as what they would get if they were an employee or a dependent in the Edison system. But that cost then gets shifted out to someone else, because the hospital has to stay in the black, it can't go in the red year after year after year.

We have seen in the charts prepared here by the CBO, this is a uniquely interesting industry where all of us who took economics—and I happen to have an advanced degree in economics—we are taught that supply follows demand, but here you have increased supply, which seems to stimulate demand for the product, and you saw it in the CBO numbers on physicians' incomes in the United States. In the face of an increasing number of physicians, the relative position of physicians in terms of earnings has stayed the same. That is not conventional theory.

Mr. McMILLAN. What we have done, it seems to me—and it is true in my community—we have engendered competition for services but no competition in cost containment, and if somebody else is going to pay for it—and that is sort of the way our system is working—then the incentive there is not to exercise any cost-benefit analysis of what you are doing, as if there is no limitation to your resource.

Mr. PEEVEY. Absolutely.

Mr. McMILLAN. And that isn't the way it is.

Mr. PEEVEY. And you said it earlier in other questions in terms of the equipment, the utilization of new equipment—always this competitive chase for something new and then passing the bill to the third party.

Mr. McMILLAN. I had one question of Mr. Sullivan. I am intrigued by the ideas behind managed care, but how would government programs interface with managed care systems? Should it be that under Medicaid, for example, we should be willing for a qualified person to enter into an arrangement under a managed care contract where the government just pays a flat annual fee and the risk of providing that care then rests upon the contractor?

Mr. SULLIVAN. Yes, Congressman. That is actually already being done in a number of States. Medicaid, of course, is a State-run program, partially federally financed, and we are in the process now of looking at some of those efforts across the country to establish

risk sharing arrangements. Of course, it requires that you be willing to pay providers a decent rate.

Mr. McMILLAN. Yes, but then how do we overcome the fear that, once we do that, that contractor is not going to live up to their obligations under that contract? So then we set up an enormous administrative system to go out and audit, and check, and monitor. Is that not going to prove to be an obstacle in that sort of arrangement? Maybe you can cite some examples where it is not.

Mr. SULLIVAN. We can generate administrative cost, obviously, by setting up any kinds of new arrangements if we don't trust providers and feel that we have to be constantly checking up on what they do.

The kind of managed care that I have tried to suggest here today, that I will admit is not yet the dominant form in the country, would aim at finding providers who are committed to the idea of providing quality care that can be measured on the basis of indicators that they can agree to, such as they have in Cleveland on a community basis, and then be held accountable by those measures, and you won't have to be constantly looking at everything that they do. That would reduce administrative costs if you were willing to agree that there are certain measures that you look at periodically to see if they are living up to the terms of the agreement with the purchaser or the financier of care.

That approach has not yet made it into the Medicaid world of managed care, so there still is substantial State oversight of these Medicaid managed care experiments, but I would like to believe—in fact, would urge—that public policy as well as what is going on in the private sector take a view of managed care that would aim at finding the providers who are committed to this process of quality improvement, as I reiterate that I do believe that quality is the key to costs as far as the way that health care is delivered and the way costs are generated—what Dr. Schroeder was referring to, the structure of the delivery system itself.

Mr. McMILLAN. Thank you very much.

Mr. BRYANT [presiding]. The gentleman from Pennsylvania.

Mr. KOSTMAYER. Dr. Schroeder, is a two-tiered system inherently a bad thing?

Mr. SCHROEDER. It depends, I guess, on the tiers. No, not inherently. If the second tier is below a certain standard, though, I think it is not what this country ought to have.

Mr. KOSTMAYER. Can Mr. Peevey's system survive in a two-tiered system in this country? What happens if we go to a national system? What happens to systems like his? Are they just thrown out and everybody at Edison has to go under some kind of national system?

Mr. SCHROEDER. My reading of our national character is that there is never going to be a one-tiered system in anything.

Mr. KOSTMAYER. Is that a bad thing or a good thing?

Mr. SCHROEDER. I think it is American.

Mr. KOSTMAYER. The Canadian system is a single tier.

Mr. SCHROEDER. Yes.

Mr. KOSTMAYER. How much waste is there in this system? Can you give us a figure?

Mr. SCHROEDER. I think there is substantial waste. I think I see waste in terms of unnecessary procedures and tests being done, and I think also one can take a look at some of the overhead and some of the profit margins.

Mr. KOSTMAYER. Can you put a dollar figure on it?

Mr. SCHROEDER. I would say, a quick answer, at least 25 percent.

Mr. KOSTMAYER. Which amounts to how much?

Mr. SCHROEDER. A quarter of \$660 billion, so \$175 billion.

Mr. KOSTMAYER. So \$175 billion in waste.

Mr. SCHROEDER. Yes.

Mr. KOSTMAYER. Are you including in that the administrative cost?

Mr. SCHROEDER. Yes.

Mr. KOSTMAYER. You are. So we could save, under reforms which would not bring about dramatic changes, about \$175 billion.

Mr. SCHROEDER. No, no. To reduce the overutilization would require dramatic changes.

Mr. KOSTMAYER. What happens if we save that \$175 billion? Is that something we should do? I gather your characterization of it as waste—really, my characterization—is a pejorative use.

Mr. SCHROEDER. Well, it is waste, and it is bad quality. That is, to the extent that you are subjecting someone to an operation they don't need, you run then the risk of them being harmed from that operation.

Mr. KOSTMAYER. Well, I understand who gets helped if we change that. Who gets hurt in the system, if we save the \$175 billion?

Mr. SCHROEDER. There are jobs and salaries that are a large part of that \$175 billion, and so there would be an income transfer to some extent.

Mr. KOSTMAYER. How many jobs, and whose jobs?

Mr. SCHROEDER. I can't answer that one, but jobs in the health care and the insurance systems.

Mr. KOSTMAYER. Whose jobs?

Mr. SCHROEDER. All up and down the line, and also relative income.

Mr. KOSTMAYER. Who is going to get hurt? Insurance companies?

Mr. SCHROEDER. Insurance companies might get hurt, a certain proportion of doctors would have lower incomes, hospitals would have less business, might have lower profit margins—all those kinds of things. So all up and down the industry.

Mr. KOSTMAYER. What happens to private insurers? They just go out business—

Mr. SCHROEDER. My understanding—and, again, I am not an expert in this—is that health insurance is not the major part of the profit of most insurance companies, but I am not the person to be the fountain of knowledge on that one.

Mr. KOSTMAYER. What are the biggest obstacles to change in this country?

Mr. SCHROEDER. I think the fact that people prefer what they have now to their second choice, they see the potential loss, and I think a second obstacle is, this is a country that doesn't trust its government. The Canadians trust their government, this country doesn't, and you have had three politicians in the last 20 years—George Wallace, Ronald Reagan, and Jimmy Carter—run for office

saying, "Government is bad; vote for me, and I'll protect you from it."

Mr. PEEVEY. Only three?

Mr. SCHROEDER. It is very hard then, in that kind of a climate. If that is a popular way to talk about government, it is very hard to trust the government to do those kinds of functions. The Canadians trust their government.

Mr. KOSTMAYER. Thank you.

Thank you, Mr. Chairman.

Mr. BRYANT. Thank you.

Dr. Schroeder, it is interesting to me that polls indicate the public in Canada right now is disaffected with Mr. Mulroney, but they do trust their government. It is interesting that Canadians are able to make that distinction between whoever is in power at the present time and the concept of a government being involved in providing a service, something which our society doesn't seem to be able to distinguish between.

I would like to ask you about the fact which was given to us in Dr. Reischauer's testimony that I asked about earlier, that 10 percent of the health care recipients in the United States account for 75 percent of our health care. I am sure that people like you have noticed that many times in the past.

Mr. SCHROEDER. I have even written a paper about it, Congressman.

Mr. BRYANT. I hoped that you had. In fact, I was tipped off by the staff that maybe you had, and I thought you could offer some reflections on that. This seems to be such an obviously fertile area for cost reductions.

Mr. SCHROEDER. It is a simple reflection of the fact that a small number of people get hospitalized each year, many of them on multiple episodes, and hospitals are very expensive. An average day in an intensive care unit is liable to cost \$2,000 or \$3,000. So you get a mother who delivers a premature child with severe lung disease, and they are liable to have a \$200,000 hospital bill. So it doesn't take many of those hospitalizations to generate a lot of dollars, and it is very simple. They don't concentrate in any particular diagnostic area. They are more prevalent in the elderly, because the elderly have more terminal illness, but you see them all along the age spectrum. They could be postponed if we paid more attention to the ravages of alcoholism and of illness from the use of cigarettes, but you would just be having those people live longer and get their terminal illness some other time.

Mr. KOSTMAYER. Would the gentleman yield?

Mr. BRYANT. Sure.

Mr. KOSTMAYER. Is that necessarily a bad thing? You just said 10 percent of the health care recipients consume 75 percent of the cost?

Mr. SCHROEDER. That is what Mr. Reischauer said.

Mr. KOSTMAYER. Is that necessarily a bad thing?

Mr. SCHROEDER. No. I think it is fact of the way technology—a fact of technology.

Mr. KOSTMAYER. You know, my father recently had open heart surgery in Pennsylvania; that is very expensive. I don't think I have ever spent a day in the hospital. He has obviously consumed a

larger share than I have, but he had to have the surgery and I didn't.

Mr. SCHROEDER. He is the 10 percent, and you are the 90 percent; that is right.

Mr. KOSTMAYER. That is not necessarily a bad thing. You treat people who are sick; you don't treat people who are well.

Mr. SCHROEDER. I didn't say it was a bad thing.

Mr. KOSTMAYER. Okay. I will tell him you said that.

Mr. SCHROEDER. He was one of the two-thirds who needed the heart operation.

Mr. BRYANT. If it is not a bad thing, then it is not a fertile area for examination by the committee for cost savings.

Mr. SCHROEDER. No. I think the waste is seen there as much as it is anywhere, and since that is high cost I think that that is an area.

I think the area of prolonging life in futile circumstances is a second fertile area, and I think we have now such supply and such fear perhaps of litigation, such conflicts about what we should do, that, in the experience that I had as a practicing physician, many, many lives I thought were prolonged unnecessarily and with suffering to patients and to family because people just didn't quite know how to stop.

Mr. BRYANT. Assuming that Mr. Kostmayer's father has lived healthily and not abused his body, then we are going to have to face his medical costs. As with people in car wrecks, assuming that our traffic laws are reasonable, there is not much we can do about that. There are several areas we can't do much about. Tell us what percentage of this 75 percent of the cost we could do something about.

Mr. SCHROEDER. There are two ways you can do something about it. One is, you could look at the appropriateness of the care, and I would guess 25 percent of that care could be dispensed with without harming patients. Then you look at, to what extent could we have prevented those hospitalizations? and you can think of isolated episodes. If you got a measles vaccination and a kid didn't get encephalitis from measles, you wouldn't have to be hospitalized. If you got more women into prenatal care, and they would do term deliveries instead of premature deliveries, you could help there. But in many people, if they are aged 55 and they have a heart attack, and they are in the hospital and generate high bills, if you did something to postpone their heart attack to age 65, you would ultimately have to pay that same bill.

So I think there is some area for help there. I don't think there is a single solution to the health care cost containment problem, and I think there have to be systematic interventions along the whole chain of the health care delivery system.

Mr. BRYANT. Last year, Secretary Sullivan issued Healthy People 2000, a listing of almost 300 national health promotion and disease prevention objectives for the year 2000, and described the document as an important milestone providing realistic and vital targets to improve the health of each American. In your view, if we do nothing to reform our health care system, can we realistically expect to achieve the national objectives set forth in Healthy People, 2000, relating to maternal and infant health, heart disease

and stroke, cancer, diabetes, HIV infection, sexually transmitted diseases, immunizations, and clinical preventative services?

Mr. SCHROEDER. No. I think they are wonderful goals, but I think if they are just grafted on to the health care system as it stands today, we are not going to get there.

Mr. BRYANT. The gentleman from North Carolina.

Mr. McMILLAN. I would just mention one other thing further on terminal health care. This needs to be checked out. We had testimony in the Budget Committee that 50 percent of all Medicare reimbursements were paid to 5 percent of the beneficiaries in the last 4 months of life.

Mr. SCHROEDER. That is probably true.

Mr. McMILLAN. That is one economic measure, and then you have got to ask the serious question, well, how many of those expenditures, or what proportion of those expenditures effected any improvement in the condition of the patient? No one is suggesting that we do anything to the contrary.

Mr. SCHROEDER. I think that is a fertile area to look further.

Mr. McMILLAN. North Carolina, as you may be aware, has taken some initiative in that among physicians in trying to address forthrightly the ethical issues and implications there, and it is a tough one but one where there are a lot of possibilities.

I would just mention one other thing and ask any of you to comment. We are looking at a better than 20 percent differential in the per capita cost of medical care in Canada and the United States, one where we say 30 percent of the population is uninsured, some portion of those receive medical care that you pay for, Mr. Peevey, and if your hospitals in your community are providing, in effect, care to anyone that walks into the trauma center—which they do in my community—it is not an efficient way of dealing with it, but it gets paid for and it gets done. So I don't know what 30 percent don't have that.

But part of that 20 percent has got to be in the whole area of defensive health care costs, and Canada has a different tort system. I don't think we are going to sell this thing by reforming our tort system, because, number one, we have got too many lawyers in the Congress, but we may be able to do some things in other ways—arbitration as a substitution of litigation.

But Canada, as I understand it, has no punitive damages, the punitive measures are disciplinary if malpractice occurs, and so then it doesn't extend a cost to the system. There is a \$150,000 limit on pain and suffering. The compensatory damages are as determined by the court. But the loser in litigation pays the court costs of the winner. And they have dramatically less litigation than we do, but I don't think those who have been harmed are getting less compensated, and I think it would bear us well to take a look at that. Do you all have an opinion on that issue?

Mr. SCHROEDER. I think malpractice reform is a potential weapon against the rising costs of medical care, but I would say it is probably not in the top four in terms of its promise for cost savings.

Mr. PEEVEY. I would agree it deserves some attention. It is not solely in the field of medicine that we have an overly litigious society. Certainly in every walk of life, though, we have this problem, and it really goes to the fundamentals. As a society, we tend to re-

solve things in the courtroom, which is preferable to some other means.

Mr. SULLIVAN. I would like to add—I am a lawyer by training—we have a tort system that needs reform, of which malpractice is a part.

One thing that might be helpful is the development of these practice standards that we hear about that are out there coming along. If they could be worked into the legal system for determining malpractice, they could at least put some certainty into the situation.

Mr. McMILLAN. We have got the information sharing technology to take quick advantage of that, but part of my point is, one of the reasons why we don't do that is the fear of litigation. If you are going to open yourself up and start comparing your procedures with some standard, then you open yourself up to potential liability.

Mr. SULLIVAN. It is a question of whether you would want that certainty of a standard or leave the situation ambiguous, the way we have it now.

Mr. McMILLAN. Did you want me to yield?

Mr. KOSTMAYER. I just wanted to ask—when we go to these meetings in our district with our physicians, as we all do, this is all we talk about. Are you saying this is way overrated, this is not the big problem that physicians suggest it is?

Mr. SCHROEDER. It is a big problem for physicians. I am not sure it is the answer to cost containment.

Mr. KOSTMAYER. Okay.

Mr. SULLIVAN. Certain physicians in particular.

Mr. KOSTMAYER. I understand it is a problem to physicians who have to pay these enormous fees to carry malpractice insurance, but to listen to physicians—and they view it from their own perspective, obviously—they would have you believe—and I am sure they believe this—that this is a major problem in the cost of the American health care system. You are saying that is just not so.

Mr. SCHROEDER. I think even the AMA says, at the most, it is \$20 to \$25 billion out of the \$700 billion health care bill.

Mr. McMILLAN. That is just the physicians' fees, right?

Mr. SCHROEDER. No, no. It is extra expenditures that the AMA has imputed are done because of the fear of a malpractice suit.

Mr. SULLIVAN. Of course, that is not inconsequential. It is also an access problem, Congressman.

Mr. KOSTMAYER. It is not inconsequential, but it is a relatively modest amount of the money that was being spent, \$25 billion out of \$700 billion.

Mr. SCHROEDER. Yes.

Mr. McMILLAN. It is enough to cover the cost of the uninsured in this country, by one estimate.

Mr. SULLIVAN. It could extend Medicaid to a lot of them.

Mr. BRYANT. If the gentleman would yield—

Mr. McMILLAN. I am going to yield all of my time.

Mr. BRYANT. I would just observe that that is not a cost that can be eliminated inasmuch as a good portion of that, maybe all of it, is going to try to make people whole again who have been injured, and those people, I presume, were not going to perfect the medical

profession to such an extent in terms of its personnel and their practices that we will never have malpractice again. We are going to still have to pay the costs of those damages, no matter what we do, with regard to tort reform.

Mr. SULLIVAN. No. I think we are actually, Congressman, thinking more of defensive medicine that may be an add-on cost to the cost generated by the malpractice legal system itself, how much medicine is practiced unnecessarily, to head that off. That is where there may be larger potential savings than the reduction of malpractice costs, per se.

Mr. BRYANT. The gentleman from Pennsylvania is recognized.

Mr. KOSTMAYER. I just want to ask Mr. Peevey a last question, if I could.

You heard Dr. Schroeder talking about excess surgery and where the waste is in this \$75 billion that goes to 10 percent of the people, and you talked about your six points. Can you give me a specific example of where you have cut costs in your system?

Mr. PEEVEY. Yes. We have taken our costs down from 23 to 12.

Mr. KOSTMAYER. How did you do it?

Mr. PEEVEY. We did it in a number of ways. We have managed care.

Mr. KOSTMAYER. What does that mean?

Mr. PEEVEY. That means there is a second opinion before utilization.

Mr. KOSTMAYER. In other words, if you have an employee whom you are covering, and that employee goes to a physician, and the physician says, "You ought to have bypass surgery," you require a second opinion.

Mr. PEEVEY. We have that option, yes.

Mr. SOKOLOV. But it even goes farther than that.

Mr. PEEVEY. That is just step one. I mean there are many others, whole pieces of this.

Mr. KOSTMAYER. I understand. I am just looking for a couple of specific things that can be done.

Mr. PEEVEY. We went to a system where we had an initial dollar coverage of employees; we went to a 90/10, so that there is some—

Mr. KOSTMAYER. So they pay something, no matter what.

Mr. PEEVEY. They pay something.

Mr. KOSTMAYER. It costs them; treatment costs them, even though it is relatively minor.

Mr. PEEVEY. Yes, right. And the idea, which I think is generally, although not universally, agreed on is that that does improve efficiency and all. We negotiated very new agreements with HMO's that brought down the costs, and because we represented 55,000 people we were able to—

Mr. KOSTMAYER. Do you think you ever lose good people because your competitors offer 100 percent?

Mr. PEEVEY. No, because in the first place we were offering and we continue to offer one of the better medical care programs in southern California. I don't think there is any employer in southern California or group of people who would claim that they have a better program. There are some that would claim that they are competitive.

Is there anything you want to add to that?

Mr. SOKOLOV. Yes, I did, because I think it is important to understand that because Southern California Edison is self-administered and self-funded, we are our own insurance company.

Mr. KOSTMAYER. Just explain to me what you mean by "self-administered."

Mr. SOKOLOV. We actually pay our own claims, we do our own utilization review, we set up our own PPO network——

Mr. KOSTMAYER. So you have hired professional people to do this rather than contracting out to companies that normally do this.

Mr. SOKOLOV. Right, exactly.

Mr. KOSTMAYER. Why does that save money? You have still got to pay these people.

Mr. SOKOLOV. Absolutely, but it is the comprehensive, strategic approach of the entire program that is really where you save your money. We have \$100 million going through this system; 92 percent, or \$92 million, actually goes contractual relationships where we know what we are spending for health care goods and services before those goods and services are delivered. That is the point Mr. Peevey was making about contracted fees; that is really important.

Mr. PEEVEY. We have 7,500 doctors. We went out and contracted with them, and they agree on our payment schedule for fees.

Mr. KOSTMAYER. Isn't that Blue Cross and Blue Shield and every——

Mr. PEEVEY. Yes, but then we administer it all. We don't have Blue Cross or Blue Shield doing this thing; we are doing the administration, the payment to the doctors, the handling of all the claims ourselves. That reduces our costs, and we do the same with 85 hospitals.

Mr. SOKOLOV. There is a big difference, though, between Blue Cross and Blue Shield in one area, and that is, again, 90-plus percent of our people go through our system. When you look at a Southwestern Bell or an Allied Signal or a variety of others, you have only 20, 30, 35 percent of the people in managed care systems. Because we are a large regional employer with 55,000 people in the southern California area, we can very much control the delivery systems in such a way so that people do utilize these programs.

Mr. PEEVEY. But it is not the panacea for all, because not everyone could do this. We have sought to hold down and control our health care.

Mr. KOSTMAYER. You can do it because of your size.

Mr. PEEVEY. We are big enough. We have market power where we are big enough to have some influence in this regard, and small employers can't do this, as we said in response to Congressman Waxman's question.

Mr. KOSTMAYER. That is why we have to go to some kind of Federal system.

Mr. PEEVEY. We need to have some sort of blended system that keeps the best of what we have, in my view, and adds to it, particularly in those areas where the situation is just egregious. We don't have to look solely to Canada. I mean if we look to West Germany, West Germany has a somewhat employer-based system that has also done a very good job of controlling costs over time. There are a number of hybrids or ways to look at this, and I think in the end

we will produce a hybrid in the United States which is uniquely American, and so be it.

Mr. KOSTMAYER. Thank you.

Thank you, Mr. Chairman.

Mr. BRYANT. How big of a group did you manage? You are a manager of an enormous enterprise. I think it should be pointed out, you are the president of the company. Isn't that correct?

Mr. PEEVEY. Yes.

Mr. BRYANT. So we have got you a little bit over into a corner of your business today. But you are a professional manager. How much of this could you manage? How many people do you think you could apply your system to and keep some control over it?

Mr. PEEVEY. Several hundred thousand.

Mr. BRYANT. How many are you treating now?

Mr. PEEVEY. Fifty-five thousand. That is employees, retirees, and dependents. We think that the program could perhaps be made more efficient if it was three times the size.

Mr. BRYANT. Maybe we should have you apply the system to all of your ratepayers, as opposed to just your employees.

Well, let me ask you another question. On page 3 of your testimony, you talk about incentives to reduce health risks. It is an interesting paragraph there. My question is whether these kinds of incentives could be utilized by the government in whatever plan we cook up, or with regard to the Medicare plan we have now. Wouldn't this work on a larger scale?

Mr. PEEVEY. Absolutely. If you meet five tests, the employee and spouse, we give them each \$10 a month if they don't smoke or agree to stop smoking, if their cholesterol is below a specific level, if they are not overweight, if their blood pressure is below a certain level or they agree to treatment for these things, and there is a fifth one I can't recall right off the top of my head—

Mr. SOKOLOV. Diabetes, blood sugar.

Mr. PEEVEY. Then that employee is given \$10 a month.

Mr. KOSTMAYER. For each of those, or for all of them?

Mr. PEEVEY. No. For all, and the spouse comes in, and we do this testing annually, and the spouse can have it too, so there would be a \$20 savings there. That concept is just a very positive one.

We are not going to outlaw some of the things in our society that—well, some things, we hope, but others—in a society that is based on a certain amount of freedoms where people are going to choose to debilitate their bodies if they so wish.

Mr. KOSTMAYER. Well, do you allow your people to eat cake?

Mr. PEEVEY. Yes, we do, and we allow them to smoke too, but off the premises. We are adopting a no smoking policy in the corporation; you go outside to smoke, not smoking in the workplace.

Mr. KOSTMAYER. Can you eat cake on the premises?

Mr. PEEVEY. Yes, you can, in the cafeteria. We point out it has high cholesterol. It has a little card that says what the cholesterol count is. We try to help people help themselves. In the end, it is their choice.

Mr. SOKOLOV. In essence, we wanted to give people the opportunity to take responsibility for modifiable risk factors, and we test almost 10,000 people annually for these risk factors.

Mr. BRYANT. Let me ask you, Dr. Schroeder and Mr. Sullivan, could we apply this nationally to whatever our health care systems turns out to be or to the one we have now?

Mr. SCHROEDER. We could do a lot better in incentives to get people to have healthier behaviors, absolutely. That is just one way.

Mr. BRYANT. But this requires screening. These people get tested every year. Is that a feasible thing to examine?

Mr. SCHROEDER. Yes. I think there is a possibility of a repercussion. That is, you could have, as some of the people in AIDS are concerned about, if you do a screening, it will be a disincentive, for example, for a company to hire someone with diabetes since their health care costs are going to be so much higher; you can predict that. Even if the diabetes is very well cared for, you can predict that they are going to have much higher costs. So there would have to be some way to preserve the confidentiality of those data, and if I were an employee I would be concerned about, frankly.

Mr. PEEVEY. But this is not a hurdle. They don't have to pass these to work at the company; these are tests that are open to them after they are in the company. People don't have to participate in this program; it is totally up to them.

Mr. BRYANT. You don't have to come in. Well, doesn't that solve the problem you just mentioned?

Mr. SCHROEDER. If you don't have to come in, then the people who don't smoke are going to come in and get it, and the people who do aren't going to, and you are not going to change behaviors.

Mr. PEEVEY. No, that is not accurate. We have people in smoking cessation programs and everything else. That is just not accurate.

Mr. BRYANT. Why wouldn't you make an attempt to—

Mr. PEEVEY. Because you have a financial inducement for them to do so.

Mr. SULLIVAN. Yes, there are carrot-and-stick approaches here, Congressman. Most companies prefer to the use of the carrot of positive incentives for positive change. There are a few companies that are using the stick, and that is, to get serious with smokers, they are charging them higher premiums.

Mr. BRYANT. The question I guess I am asking is an administrative question. We have 240 million in this country. Can we screen people? Can we do those kinds of things? Is that possible? Maybe I am asking the wrong people this question.

Mr. SOKOLOV. I think the answer to this—and my background is in cardiovascular risk management and preventive medicine, and I have designed programs historically for IBM and AT&T and Southwestern Bell in addition to Southern California Edison. The answer is that it has to be specific to the population you are dealing with. We chose our risk factor modification at Edison because the average age of our employee is 45, the tenure with the corporation is 16.8 years, the turnover rate is less than 5 percent, and the ratio of males to females is 3:1. It is an ideal cardiovascular risk modification population.

If we wanted a national preventive health program, we would have to basically design it in such a way, taking into consideration what the major preventive health costs are from a national perspective. I would suspect that in certain areas we are going to see a

greater return from a prenatal type of counseling than we will from knowing someone's cholesterol, if you are an 18-year-old child-bearing female, for instance.

So these are some of the issues. Administratively, we can do a great deal more nationally in terms of preventive health.

Mr. BRYANT. Okay. Did you want to comment?

Mr. SULLIVAN. No. I agree entirely with what he said. The problem with this kind of program is that a lot of people have not been able to show a bottom line justification for it yet. That is beginning to change. Johnson and Johnson came out with a study this year that showed that their program was very cost effective, and they are now selling it to other companies.

Mr. BRYANT. I have one last question.

Dr. Schroeder, one of the important political elements in this whole process is the expectation of physicians for the kind of life they are going to lead after they leave medical school. Comment on that if you would. I think that, generally speaking, people think doctors are folks that are going to drive Buicks and be in the country club and live in a bigger house than the rest of us, and I am not complaining about that necessarily. How does that compare to other countries in what their expectations are?

Mr. SCHROEDER. I think the whole area of health manpower and the numbers of doctors we have and the kinds of doctors we have is a very important issue in determining the shape of our health care system and how much it costs. If I had a criticism of our system right now, it is not that it has too many doctors, it is just that it has too many specialists, and the specialists generate a lot more expenditures than a generalist would. In particular, in some of the rural areas we have a problem.

Now why do so many go into specialty areas? Part of it is because medical school is so expensive, many of them leave with great debts, and the way we pay doctors, we pay them much, much more per hour if they involve a technology, whether they are in radiology or anesthesiology or in one of the surgical specialists, rather than if they are doing general care. We can pay sometimes as much as 20 times per hour more for doing something with a technology than not. So I think that the way the system is structured and how we pay doctors has a major impact not only on the kinds of careers that physicians choose, that medical students choose, but also in cost of medical care.

Now what are their expectations? I think there are some new factors. Something like 40 percent now of all medical students are women. Women tend not to want to work quite the work hour that older physicians, like me, used to do. They often marry someone who is a professional. They often look for salary jobs. So often life style issues are more important than share of income.

But I think one of the issues that has puzzled me as we have looked at cost containment strategies and the discussion is, we tend to leave the whole issue of doctor supply out of it, and that doesn't make any sense to me.

Mr. BRYANT. The whole issue of doctor supply?

Mr. SCHROEDER. How many doctors you have, and what they do, and where they are, and how they get paid.

Mr. KOSTMAYER. If the chairman will yield.

Mr. BRYANT. Sure.

Mr. KOSTMAYER. What you are saying is, there are too many specialists.

Mr. SCHROEDER. Yes, and I think that drives the system in ways——

Mr. KOSTMAYER. I can't remember the last time I went to a general practitioner. I always go to specialists. I went recently to an orthopedic surgeon because I had a pain in my knee. You are a doctor, but when is the last time you went to a general practitioner, not to a specialist?

Mr. SCHROEDER. I go to a general internist. Last summer.

Mr. KOSTMAYER. Thank you, Mr. Chairman.

Mr. BRYANT. All right. Thank you very much on behalf of the chairman of the subcommittee for a very fine morning.

[Whereupon, at 11:55 a.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM

Proposals for Expanding and Financing Coverage

MONDAY, JULY 29, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order. This is the second in a series of hearings that the subcommittee is holding on health care reform. At our first hearing, we received a sobering lesson in the consequences of inaction. If we do not enact health care reform, the costs of health care will continue to rise to a rate of 12 to 15 percent each year over the next 5 years.

These cost increases will make it very difficult for those employers, especially those small employers, that now offer health care coverage to their employees to continue to provide health care coverage. And it will make it even more difficult for those employers, especially those small employers, that do not now offer health care benefits to begin to offer this coverage.

This, in turn, means that there will be more, not fewer, working Americans and their families without basic health insurance coverage.

With more Americans uninsured, hospitals and physicians will have no choice but to shift the costs of caring for the uninsured to those who are insured.

Large employers will be able to protect themselves against much of this cost-shifting because of their market clout. Small employers, however, will not have the leverage to negotiate low rates with providers. This may prompt even more small employers to drop their coverage.

As more Americans become uninsured, it will be impossible for us to achieve our national health objectives for the year 2000. Clearly, the system is broken and it needs to be fixed.

This morning, we are going to hear from various members who have introduced, or are about to introduce, health care reform proposals on how the system ought to be fixed.

These proposals fall into two broad categories: those that would build upon the existing system of employer-based coverage, and

those that would replace the employer-based system with a public plan, whether Medicare or some other single-payor program.

I have introduced H.R. 2535, which is based on the recommendations of the Pepper Commission and which builds on the existing employer-based insurance system. Under this bill, Americans would be covered for basic health care benefits in one of three ways: through their employers, through a new Medicare-like public program, or, in the case of the elderly, through Medicare.

To control costs, my bill would make public payment rates for services available to private plans. The mixed public-private approach in my legislation is not necessarily inconsistent with the single payor, public plan approach.

In fact, through the design of the "pay-or-play" rules, an employer-based system could be structured so that, over time, more and more Americans would be enrolled in a public plan as employers decided it was less expensive to "pay" a fixed percent of payroll and enroll their employees in the public plan than to "play" by purchasing private health coverage.

The Pepper Commission bill has been introduced in the Senate by the chairman of the Commission, Senator Jay Rockefeller. Unfortunately, he was unable to join us this morning.

However, without objection, I would like to include in the record a statement from the Senator explaining the Commission's approach.

[The prepared statement of Senator Rockefeller follows:]

The Honorable John D. Rockefeller IV
 TESTIMONY SUBMITTED TO THE SUBCOMMITTEE
 ON HEALTH AND THE ENVIRONMENT
 U.S. HOUSE OF REPRESENTATIVES
 July 29, 1991

I am extremely honored to have jointly introduced legislation with Representative Waxman, Chairman of the Energy and Commerce Subcommittee on Health, based on the recommendations of the Pepper Commission. Congressman Waxman has long been an advocate for health reform, in particular for expanding access to health care for children and pregnant women. And, he has been remarkably successful in his efforts. I am proud to be joining him in the fight for access to health care for all Americans.

I have also recently joined my Senate colleagues, including the Majority Leader Senator Mitchell and Senators Kennedy and Riegle, in introducing major health legislation that builds on the work of the Pepper Commission. These bills are very similar in their job-based approach to achieving universal access to health care.

Today's call for health care reform has a new urgency. Uninsurance is no longer just a problem for a minority of Americans. The majority of our citizens -- hard working Americans who get health coverage through their jobs -- see the system they count on in serious danger.

The Pepper Commission spent more than a year deliberating and weighing alternative approaches to health care reform. It is constantly said that a consensus eludes us because the issue is so complicated. But as we learned in the course of the Commission's work, when it comes right down to it, we don't have a lot of choices on how to do the job.

Some say we should limit our sights to modest, incremental steps, usually expansions in Medicaid coverage, and hope for the best. But the Commission concluded that patching the system is simply not enough. Even if Medicaid were greatly expanded -- to cover all the poor -- and the near poor got subsidies for private insurance, insurance would remain too expensive for about half the Americans who now lack coverage (more than 14 million Americans). And taxpayers would bear the costs of insurance for workers whose employers, unlike most employers, do not provide coverage.

The Commission also rejected a single-payer, government-run national health insurance program. Not because all of its members didn't like it; in fact, for several members, national health insurance was their first choice.

But the majority of the Commission ultimately concluded that their job was not to put forward an ideal system. It was to recommend a doable system. Most Americans now have health

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insurance that can be made to protect them; and most health insurance is purchased with private funds. Our Commission believed that to try to shift so many people and so many dollars -- an estimated \$209 billion -- from the private to the public sector is neither fiscally sound nor politically pragmatic.

In sum, our Commission concluded that to achieve universal health care coverage in anything like the immediate future, as we believe essential, we can neither patch nor replace current coverage. Rather, we must secure and extend the combination of job-based and public coverage we now have into a system that truly guarantees adequate coverage for all Americans and that ensures efficient and quality health care in private and public coverage alike.

The Pepper Commission recommendations, which are embodied in the Pepper bill, S. 1177, and the Senate Democratic Leadership bill, S. 1227, are as follows:

First, all workers must be entitled to health care coverage in their jobs, just as they are entitled to a decent minimum wage or participation in social security. Three quarters of all workers now get health coverage through their jobs; three quarters of the uninsured are workers or in workers' families. If all employers covered employees and their dependents, as most do now, we'd be well on our way to universal coverage.

Since almost all large employers now provide coverage, getting all of them to do so involves little change. Therefore, after a brief period for adjustment, employers with more than 100 workers would be required to cover employees and their nonworking dependents.

On the other hand, many small employers now face formidable barriers to buying coverage -- hurdles that must be dismantled or overcome. Therefore, we provide for small group insurance reform that would guarantee open enrollment, community rating and access to a federally-defined minimum standard of benefits -- reforms aimed to make coverage available to small groups. Tax credits would also be provided to small employers to reduce their insurance costs, and the self-employed would be able to deduct 100 percent of the costs of health insurance that satisfies a basic benefit standard.

These reforms should help small employers obtain the coverage they say they want. But if this help is insufficient, and, after four to five years, workers in small businesses are still without coverage, small businesses, like large businesses, would be required to provide coverage to their workers.

Second, just as it is the responsibility of business to insure its workers, it is government's job to assure that businesses can obtain affordable coverage. Rather than simply requiring any employer to buy private coverage, whatever its costs, employers would have a choice: purchase private coverage

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or purchase coverage from a newly-established public program at subsidized prices. The price for public coverage would be set not to eliminate the private insurance that many Americans want very much to retain, but to make insurance affordable for employers of low-wage workers.

Third, in order to assure subsidized access to a decent public program for non-workers, along with workers whose employers find public coverage more affordable, Medicaid would be replaced with a new federal program that would provide the same minimum standard of benefits that employers would have to provide. The public program would pay providers rates based on Medicare rules, in place of Medicaid's abysmally low rates.

Finally, for all Americans, insured and uninsured, action is needed to contain medical costs and assure quality of care in public and private coverage. These objectives would be achieved through a number of actions, including: a basic benefit package that emphasizes prevention and consumer cost-sharing; the encouragement of managed care and other innovative delivery mechanisms; extension of Medicare's increasingly effective methods of provider payment to the new public program; and data collection, outcomes research, and practice guidelines to help public and private payers alike use their dollars wisely.

Under the Senate version of the Pepper bill, S. 1177, small employers would have the opportunity to elect the use of Medicare reimbursement rates. This would give small businesses the market clout of the Medicare program in negotiating reimbursement rates, helping to bring down their insurance rates. The Senate Democratic Leadership bill includes a similar provision but limits the Medicare election to previously uninsured small businesses for a period of five years.

The Senate Democratic Leadership bill also includes, at my urging, even more significant measures aimed to holding down health care costs. This bill creates a federal-level health expenditure board to establish national and state-level spending targets and convene negotiations between purchasers and providers on reimbursement rates; and a state-level entity that, at a minimum, would be required to process claims for insurance companies with small market shares.

I believe these are the elements of workable and comprehensive health care reform -- reform that extends and secures coverage and shares and contains costs. Putting the private and public pieces together and making them work will take commitment and effort. It is not as pure and simple as starting over, through national health insurance. But I would argue that holding out for starting over is to hold millions of Americans -- who are now or about-to-be uninsured -- hostage to a politically infeasible concept of an "ideal" system. As long as an reasonable alternative can work, and I firmly believe it can, it is unconscionable not to pursue it.

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And I propose that we get going: we should pursue an approach like the Pepper Commission's with confidence that the time has indeed come for action to resolve our health crisis.

Whenever I make this plea, the obvious question is "where do we get the money?" The full cost of the Pepper Commission, when fully in place, is estimated to require an additional \$24 billion in federal spending. I am absolutely convinced that we can shoulder the extra costs of shoring up our health care system by preventing the much greater and tragic costs of inaction. We have seen again and again that when Americans perceive a crisis and their leaders galvanize around a reasonable solution, we commit the necessary funds. The Pepper Commission identified a number of constructive ways to raise that money, sharing burdens fairly across the population. If our President and the Congress could agree on a program, I believe we could raise the necessary funds.

And I disagree with those who say we can't do it now; that there is too little consensus to move forward. For one, we have already begun to move forward. At the end of the last Congress, we enacted new coverage for children, home care for seniors, and insurance reform -- for Medigap -- that start us down the very step-by-step path to universal coverage the Pepper Commission recommended.

Health care reform will require seeing past the criticisms and concerns of a long list of vested interests that want someone else to make the concessions or break the gridlock. A comprehensive solution should be based on the principles of burden sharing and fairness -- principles that have proven to make sense to the American people.

No one -- not Congress, not the President, not the insurers or the businesses or the providers or any one else -- can any longer afford to throw up their hands and say: This issue is just too complicated; we've got to study it, think about it, massage it some more. Instead, we should roll up our sleeves and get going -- broker the compromises, educate the public and make reform a reality.

I don't deny this will be hard work, substantively and politically. But for both moral and economic reasons, we have to rise to the challenge.

Mr. WAXMAN. As the Senator's statement makes clear, the need for reform is urgent, and the costs of maintaining the status quo are staggering.

There are a number of proposals out on the table. Notably absent, of course, is any proposal from the Bush administration. Health care reform just doesn't seem to be a high priority at the White House. Evidently, they are: too busy stopping doctors from giving their best advice to patients in public clinics, too busy outlining politically correct research projects, too busy cutting Medicare physician fees, and too busy telling states how they can spend their own tax dollars.

The purpose of this hearing is to help us understand these proposals and how they differ from each other.

I also hope, however, that this hearing will help us to move to the next stage of developing and enacting legislation that will pass the House, because we simply cannot afford to do nothing. The costs of inaction are just too high.

Before calling on our witnesses, I want to recognize members of the subcommittee for opening statements and recognize Congressman McMillan.

Mr. McMILLAN. I thank you, Mr. Chairman, and thank you for holding this hearing today, as well as others on health care reform proposals.

I look forward to the testimony of our two experts and also our colleagues on bills that they have introduced that would help reform our system.

I might just respond briefly to the chairman's comments about the administration. I really don't think that the solutions to health care in this country are going to be partisan.

I think by and large they are going to require bipartisan efforts to get anything done because if they were truly partisan, then I am sure that the Democratic Congress would have solved all the problems over the past 40 years that it has dominated the House.

So that being said, let me point out one approach that I am taking that is bipartisan. In September, the leaders in my community, Charlotte, N.C., which will include active decisionmakers in medical care, beneficiaries, the business community, even the legal community, will be forming a task force that will examine problems within our health care system in that regional system, and they are a mirror of the national problems or the national problems are a mirror of the regional systems all across this country.

They will attempt to identify the forces that are driving up health care costs, and they will also examine the proposals that members of Congress are introducing and others as potential solutions to the problems of cost and lack of accessibility.

Hopefully, they will not only be able to address those problems but will also, perhaps, be willing to face up to some of the difficult tradeoffs that are necessary before any health care reform proposal is going to be successful, something that is extraordinarily difficult, as we know.

I believe that any plan, to be successful, must include several parts. First, it must contain a plan to attack the cost drivers in the system, and these cost drivers include medical malpractice liability costs and especially the indirect defensive medical practices that

they engender; the overutilization of services in the system; the unbalanced health insurance practices that raise prices and curtail coverage; excessive overhead, both private and public reimbursement systems; excess hospital capacity and overdeveloped costly high tech equipment that is often purchased when we haven't even begun to utilize the last high tech advance.

Second, reform must address the problem of the delivery system. If we are able to make health care more affordable, we must also make sure it is also accessible.

The working poor typically suffer most from lack of access to health care. They do not receive preventive services. They delay health care until their health needs are more critical, and then often they have to resort to emergency treatment, which is not designed to provide comprehensive care.

Third, we must develop a way to retain and improve the high quality of medical care in this country, and I think we would agree that we probably have the highest quality care of any nation in the world.

Research that documents the effectiveness of procedures and that collects and analyzes physicians' practice patterns can provide hospitals and doctors the information they need to provide efficient and effective treatment.

With this information, physicians can determine if they perform too many procedures and tests or not enough. But a litigious society mitigates against the exchange of that kind of information because it is too risky to exchange it.

With quality standards, we will have another tool in place that will help guide the level of services that physicians provide, rather than our current system in which defensive practices determine the level of services.

Similarly, this information will make hospitals and physicians compete based on the quality of their care rather than on the basis of how much high tech equipment they have.

Cost containment, the delivery of health care, quality health care and quality effectiveness standards must be a part of any rational, workable plan.

Mr. Chairman, again I thank you for holding this hearing, and I look forward to our testimony this morning.

Mr. WAXMAN. Thank you very much, Mr. McMillan.

Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman, and let me join with my colleague to commend you again for holding this important hearing. There is no issue before this committee of greater importance to the American public.

You know, at our hearing 3 weeks ago, we heard testimony from CBO Director Reischauer on the strengths and weaknesses of our health care delivery system.

CBO noted, and we must not take lightly, many strengths in the U.S. health care system: A substantial majority, some 85 percent, of the population has health insurance. For this segment of the population, there is access to care without waiting with few limits on choice of providers, type of coverage and treatment alternatives.

Our societal investment in biomedical research, coupled with the current reimbursement system, encourage rapid transfer of new technologies that provides the highest quality of care in the world.

If I may digress for a moment, in my view, Friday's vote on the NIH reauthorization bill under your leadership, Mr. Chairman, expressed the solid support of the House for the principle that the NIH remain at the cutting edge of biomedical research, whether it be the mapping of the human genome, expanded research on the health of women and critically important, if sensitive, areas such as fetal tissue research and research on human sexual behavior.

Yet, in sharp contrast to the basic strength of the system, the CBO noted that many believe that the health care system has serious flaws.

As Director Reischauer observed:

Substantial numbers of people remain without health insurance, either private or public, and health care spending per person is much higher than in other countries and is rising faster than the gross national product.

Dr. Reischauer went on to note the dilemma of addressing the problems of cost and access:

Since policies to address one of these problems may cause a worsening of the other one, we may anticipate further deterioration of insurance coverage or continued rapid increases in spending for health care.

The importance of, and interdependence between, the problems of cost and access have been identified by many. In this regard, I note the striking similarities between the CBO testimony and recent Congressional testimony by OMB Director Richard Darman.

As Mr. Darman observed:

Although real per capital health expenditures have been rising dramatically, there are reasons to be disturbed about both the adequacy and the distribution of the return on this increasing investment.

It is often said in the Halls of Congress, "If it ain't broke, don't fix it." Mr. Chairman, there seems to be a consensus that with regard to our health care system, "If it ain't fixed, it will get more broke."

Unfortunately, the more broken the system gets, it will translate into the human pain and suffering for my constituents in Oklahoma and millions of others across the country.

Today's hearing centers on a presentation of alternative proposals for reforming the health care system. The proposals are varied. They range from creation of national health insurance through a single-payor plan; "pay-or-play" joint public-private proposals; State-based reform plans; and imposition of additional cost and quality control mechanisms.

Still other proposals alter the balance between financing through taxes and premiums, propose major changes in the role of both public and private insurers, or call for the reform of the malpractice system.

I look forward today to learning more about the various proposals for reform. That there is as of yet no clear consensus on the best solution to the problems reflected in the diversity of the views of my Congressional colleagues who will present their thoughts today.

I am confident, however, that over time a consensus will be reached. Too much is at stake for the 33 million Americans with no health insurance and the many millions more with inadequate protection and the businesses, both large and small, that face the ever upward spiral of health care costs. For us not to succeed would really be a crime.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Synar.

Some weeks ago I had the opportunity to cosponsor a briefing on a new book that focuses on the need for health care reform and implications of alternative public policies.

The book, "Serious and Unstable Condition: Financing America's Health Care," is authored by Dr. Henry Aaron, who is the Director of Economic Studies at the Brookings Institution, and he is our first witness today.

Dr. Aaron is a nationally recognized economist whose writings about the health care sector have helped us better understand the dynamics of health care financing and its relationship to other parts of the economy.

We have asked Dr. Aaron to summarize for us his recent analysis of the health system and his assessment of the effects of alternative models that have been offered as reform strategies.

Dr. Aaron, we are delighted to have you with us today. Your complete statement will be in the record in full. We would like to ask if you would to summarize your presentation in around 5 minutes, as remarkably little time as that may seem, so we will have a full opportunity for questions and answers.

There is a button on the base of the mike. Push it forward. We are looking forward to hearing your testimony.

STATEMENT OF HENRY J. AARON, DIRECTOR OF ECONOMIC STUDIES, THE BROOKINGS INSTITUTION

Mr. AARON. Thank you very much, Mr. Chairman.

I want to repeat my thanks for your kindness in cohosting that event a few weeks ago.

I am going to skip the first two sections of my testimony, partly because the first section has been so neatly summarized by Mr. Synar, yourself and Mr. McMillan on the need for action now rather than waiting for a later date.

I am going to skip directly to the third section of my testimony in which I divide the menu of health care financing reforms a little more finely than you did in your opening remarks; but the structure is similar, and I try to grade each of four different major options for reform in four different dimensions.

The dimensions are, first of all, does the plan assure financial access to care for substantially all Americans.

The second issue is does the plan hold out the promise for cost control. No plan guarantees cost control. It simply may create a mechanism within which control is possible.

The third dimension is does the plan significantly redistribute the costs of current care.

The reason I think this is important is that the greater the degree to which any proposal for reform redistributes income ancil-

lary to the main objectives of cost control and assuring access, the less the chance it has for being enacted.

Even further, as I am very disturbed about the increasing inequality of income in the United States, it seems to me that the objective of addressing that problem in this case is at war with the objective of achieving health care financing reform.

The final dimension is the question of whether the plan supports or conflicts with important values embodied in American political and economic institutions.

In these four dimensions, the first of the major approaches to reform which I describe is incremental, involving modest changes in the private insurance system and some modest extensions of Medicaid.

I suggest this just barely survives stalling on the count of access and cost control, but this approach does not offer any credible promise of dealing effectively with these two problems.

It does very well on avoiding needless winners and losers, and it may be one reason why this approach enjoys a good deal of popularity. And clearly, it is also congruent with existing values as expressed in political and economic institutions.

So on those scores it is very easy to continue trying to do what we have been doing in the past, but do it a little better.

My fear is that that is the road to higher costs, and less access, as you suggested.

The second general approach is the introduction of a large scale system of tax credits payable to individuals to defray the cost of health insurance. This approach, it seems to me, ranks either a roaring A or a flat B.

If on the issue of access, depending on the adequacy of the tax credit to cover essentially all of the costs of care, and on whether the purchase of care is mandatory or optional.

On the issue of cost control, it seems to me this approach has little chance of achieving major gains because it simply would extend the malaise, if you will, in the current health care system that leads to raising costs.

Specifically, the fact that fully insured patients confront fee-for-service physicians, and that is a combination that is guaranteed to give you rising costs.

On the needless winners and losers, the tax credit approach ranks low because one is going to replace very sizable private outlays with increased taxes. And there is no way that you match up those payments. You are inevitably going to produce large numbers of winners and losers.

I suggest there are a good deal of value congruents. This fits in well with traditional ways of doing business in the United States. It is a mixed grade.

The national health insurance, and I have just a half minute left, ranks very high on access in cost control. It is at the bottom of the list. I am producing needless winners and losers, shifting about \$300 billion at a minimum from private budgets to public budgets. And it does violate traditional American ways of handling this particular problem.

The final approach is some kind of mandatory employer-financed insurance with a public backup analogous to the same category of plan you introduced and others have supported.

On the issue of access, I think it ranks a pretty good grade A-minus to B-plus. It ranks below national health insurance because it is notably more cumbersome in achieving access.

On the issue of cost control, it could be an A, if it's combined with effective mechanisms for controlling costs. And I would suggest those are primarily subjecting hospitals to fixed budgets and physicians to fee schedules.

In terms of winners and losers, it ranks a fairly good grade, about a B, maybe a B-minus; and on value congruents, it probably ranks a B.

The chief strike against it is that it entails mandating yet another action by employers or subjecting them to an additional tax, not a popular thing to do.

I didn't take a position in this in my testimony, although I do in the book presented at the affair that you cosponsored on which of these options is the most promising to pursue.

[The prepared statement of Mr. Aaron follows:]

Testimony of
Henry J. Aaron¹

before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

July 29, 1991

Mr. Chairman:

Thank you for the invitation to testify before the subcommittee on Health and the Environment of the Committee on Energy and Commerce on options for reforming the system of financing health care in the United States. While I have views on the directions such reforms should take, I shall not use my written remarks to advocate any particular set of reforms, but shall try to make three major points regarding the options confronting the United States.

First, reform in the system of finance is badly needed and should be undertaken sooner rather than later, because the problems created or aggravated by the current financing system are likely to grow steadily more serious. For that reasons the costs of delay will increase steadily.

Second, history matters. The redesign of the U.S. health care system will not be written on a clean slate. The current system is administered by hundreds of thousands of people and operates through millions of separate contracts. Advocates of change should recognize that modifications in the current system, however much it may deserve to be changed, will impose real costs of adjustment, including threats to the job security and incomes of some of those who make the current system work.

Third, since most Americans have health insurance and most of those have good health insurance under financial arrangements that are well established, reformers should understand that no major change in that system is immune from serious and legitimate criticisms. It is impossible to make major changes in arrangements affecting as many people as health insurance does without making many people worse off, as the price of making, it is hoped, even more people better off. I would urge that the reforms that should rank highest are those that minimize the amount of income redistribution that is incidental to the fundamental goals of health insurance reform.

¹Henry J. Aaron is the Director of Economic Studies, The Brookings Institution. The views expressed in this statement do not necessarily reflect those of staff members, officers, or trustees of the Brookings Institution.

I

On the need for reform of the current financing system I shall be brief, because everyone seems to agree that the current system is seriously flawed and needs to be modified. Unfortunately, some comment is necessary, because reform of health insurance is yet another illustration of Miles law, "Where you stand depends on where you sit."

Individuals and groups speaking for the uninsured stand for the extension of health insurance coverage. Many tend to dismiss cost concerns, holding out exaggerated hopes for one avenue to savings or another, such as reforms in administration, the elimination of useless care, or the more efficient production of health care. The truth is that although sizeable savings can be achieved in each of these areas, certainly enough to pay the added costs of services for the uninsured, the cost of health care in the United States and in all other developed countries will continue to rise and to rise fast, unless we decide that some beneficial care is just too costly and that we as a people would be better off without it. Just eliminating waste, including administrative waste is a worthy objective and can save billions of dollars, but these are one-time savings that cannot hold down for very long the increase in spending that is largely traceable to the proliferation of beneficial new medical technology.

The resource cost of extending care to the uninsured is actually quite modest. Roughly 14 percent of the American population is uninsured. This group receives sizeable amounts of care—probably half to two-thirds as much as the rest of us receive on the average—through care they buy themselves or receive through the charity of others. Thus, the resource cost of providing the uninsured as much care as the rest of us consume on the average is about 5 to 7 percent of total health care spending, or about \$ 25 billion to \$ 40 billion per year.

This cost is not trivial, but 5 to 7 percent is the average increase in real health spending that the United States experiences in one year to eighteen months. Moreover, U.S. health care spending has been rising at about this rate for forty years. If truth be told, the cost of providing all Americans financial access to care is not a very big economic deal.

But it is a big deal politically, because the current system is incapable of providing that access. Furthermore, the current system is becoming progressively less capable of providing even as much coverage as it now offers. As fast as the U.S. Congress can mandate extensions in medicaid coverage, the private insurance system is deteriorating as a vehicle for insuring large groups within the U.S. population. Risk rating by private insurers, which makes insurance unavailable to some groups and unaffordable for others, is not an act of greedy mendacity, but a survival strategy for companies in an industry subject to increasingly vigorous price competition. And if you think things are tough now, just wait for the further refinements of tests based on advances in molecular biology and genetic research that will accurately forecast the likelihood of future illnesses and susceptibilities to work place hazards. Private insurance is on its way to becoming a form of prepayment, not insurance. Armed with knowledge about who will get what illnesses when, insurers will be forced to charge each client or group the full expected, and increasingly accurately forecast,

costs of care, however high those costs may be. The result will be that those most in need of insurance will find it harder and harder to pay the price for coverage.

Furthermore, the technological revolution that principally explains the rise of health care spending shows no signs of abating and many signs of accelerating. The shortening of hospital stays, which helped prevent the growth of health care spending during the 1980s from being even higher than it was, cannot be indefinitely extended. These two facts mean that forces driving up health care costs will be at least as formidable during the 1990s they were during the 1980s. Faced with rising costs, employers will continue to try to shift costs to employees through higher premiums, deductibles, and other forms of cost sharing. The temptation of employers to forego coverage for dependents or themselves will increase. Employers are not to be criticized for behaving this way. Under the discipline of market competition, which in most other areas serves us surpassingly well, they cannot really do otherwise.

Confronted with these forces, many of those whose concerns are focussed on extending financial access to care argue that enormous savings can be achieved without sacrifice of beneficial care that will more than pay for the added costs of serving the uninsured. Many of those who are primarily worried about rising costs—business executives, elected officials who have to meet seemingly uncontrollable public health care budgets, and others—cherish similar hopes. Some claim that shifting to a Canadian-style system will save 10 percent, or perhaps even more, of total health care spending through reduced administrative costs. Others believe that effectiveness analysis will discover a long menu of services provided in excess to innocent patients by ignorant or greedy physicians. Some think that malpractice reform will end the waste of defensive medicine that doctors practice out of fear of litigation and large settlements. And many firmly believe that preventive measures will reduce the incidence of illness and attendant costs of care.

A lack of space and time prevents me from addressing each of these claims, which I explore at length in *Serious and Unstable Condition: Financing America's Health Care*, just published by the Brookings Institution. Some of these claims are almost certainly exaggerated (for example, there is little prospect that preventive health measures or malpractice reform will perceptibly affect the growth of health care spending). Others potential economies—for example, the administrative savings from simplification of the payment system—are very large indeed. But none of these savings go very far toward meeting the concerns of those currently responsible for paying for health care.

The reason is quite straightforward—all of these savings represent a one-time reduction in health care spending by a given *amount*, while the principle force driving up the costs of health care spending—technological advance—adds a *few* percent to total spending *every year*. A steady increase in real health spending of 5 percent per year rapidly overwhelms any savings that can be achieved from administrative simplification, malpractice reform, elimination of useless care, or other claimed panaceas for rising costs. The simple fact is that, as one of the early Rothschilds remarked, compound interest is the eighth wonder of the world.

What this all adds up to is the need for prompt action both to extend coverage and to put in place an administrative framework that will permit us to control the growth of spending. Without such action, we can look forward continued rapid technological advance in medicine, associated increases in costs, and measures to combat those costs that tend to increase the numbers of uninsured. You should not cherish the illusion that malpractice reform, effectiveness research, preventive health measures, or any of the other panaceas advanced to cure the problem of rising costs will work.

II

More than 200 million Americans are served by private health insurance and public programs that spend a grand total of more than \$700 billion, one eighth of national production. All plans to extend coverage to the currently uninsured require that someone pay the costs of that added care. These costs can be met in various ways, but all share a common feature—the income of some group will be reduced, through taxes in some cases, through premiums in others, or through reduced payments to those now rendering services (such as administration) that some people regard as unnecessary. It is these reduced incomes that make the extension of health insurance coverage so difficult. Each person or business who suffers a drop in income is a potential opponent of extending health insurance. Usually they do not question the value of extending coverage. They just wonder why they should be asked to bear so large a part of the cost. Or they want assurance that the steady rise in health insurance costs will be brought under control.

If the higher taxes or reduced incomes went entirely to pay for added care for the uninsured, the obstacles to reform would not be nearly so high as in fact they are. \$25 billion to \$40 billion, less than 2/3 of 1 percent of national product, is not a high price to assure universal coverage and cost control. But all proposals to reform health care financing that would do more than marginally change the current system incrementally entail large additional shifts in the costs of services that are provided now and would be provided under the new scheme. Premiums would be reduced or imposed; taxes would be added or replaced; tax credits would be introduced and exclusions terminated; private payments would be raised or lowered. Every such shift generates gainers and losers.

If adding the ranks of losers and gainers left the political balance unaffected, these shifts in financial burdens would not be important. But losers complain more loudly and vociferously than winners. Imposing these shifts violates the principle that guides much political action and that was first characterized by my colleague, Charles Schultze, "Do no *visible* harm." When costs are shifted, they are not shifted randomly. Particular occupations, industries, regions, states, or congressional districts pay more than average. Representatives of these groups join those who might oppose health care financing reform on other grounds. The ranks of opponents of change multiply.

It is for this reason, that I urge supporters of reform of the current health care system to refrain from endorsing or sponsoring proposals that entail large amounts of income redistribution...at least if you want reform of health care financing. However attractive such redistribution may be, however disgusted you may be (as I am) by the sharp increase in economic inequality in the United States, attempts to deal

with that issue as part of a health bill will drastically reduce the chances of reforming health care financing and extending coverage to the currently uninsured.

III

So many proposals to reform the health care system have appeared in the past couple of years that this activity, quite apart from the health care system itself, seems to be absorbing a significant proportion of gross national product. Despite their number and differences, the reform proposals fall into four major categories. I shall use the remainder of my testimony to suggest the strengths and weaknesses of each of these options. Harking back to my time as a college teacher, I shall give each of these options a grade in four dimensions.

1. Does the plan assure financial access to care for substantially all Americans? *[Access]*
2. Does the plan hold the potential to reduce expenditures on low-benefit, high-cost care? *[Cost Control]*
3. Does the plan significantly redistribute the costs of current care? In other words, to what extent does the new system produce winners and losers for reasons unrelated to either of the first two reasons? *[Losers and Winners]*
4. Does the plan support or conflict with important values embodied in American economic or political institutions? *[Value congruence]*

Clearly, a plan that assures access and enables cost control ranks higher than one that does not. I shall award a higher grade to a plan that produces relatively few losers and winners, not because the current distribution of income is meritorious, but because extensive redistribution reduces the chances that a plan to reform health care financing will be enacted. Likewise, a plan that affirms economic and political principals cherished elsewhere in American life stands a better chance of being enacted soon than one that does not.

No plan rates high grades in all four categories because changes large enough to assure coverage and to control costs must produce many winners and losers and is likely to conflict with traditional ways of doing business, which are after all the ones that result in large numbers of uninsured and an inability to control spending.

Incremental Reform

Access	Cost Control	Needless Winners And Losers	Value Congruence
D	D	A	A

The incremental reform strategy comprises many diverse proposals to ameliorate specific problems with the current health care system. "Risk pools," amalgamations of many small groups into large ones, would be established for small employers who often face exorbitant premiums, in part because insurance companies fear that groups with the highest expected costs are most likely to seek insurance. Various proposals have been advanced to set ceilings on allowable premiums and provide public subsidies if necessary to offset losses. Some proposals would allow employers to offer lean benefit packages that many states currently prohibit.

The incremental strategy would extend medicaid coverage and possibly lower the age of eligibility for medicare. It would encourage the use of "managed care" by private insurers, a set of procedures to encourage patients to choose low-cost providers and to curb the prescription of useless services by hospitals and physicians. It would reform the malpractice insurance system, based on the widely-held, but unsupported, view that malpractice insurance and care induced to reduce risk of litigation—so-called defensive medicine—has contributed significantly to rising costs.

The incremental approach entails no major disturbance in current arrangements. For that reason, it causes few unintended winners and losers and is quite consistent with the prevailing system of voluntary employer-sponsored insurance. This approach does little to offset the tendency of current employer sponsors of health insurance to drop plans because of sharply rising costs of care. As a result, the *net* increase in the number of people added to the roles of the insured is likely to be negligible. Extensions of medicaid and medicare would increase coverage, but incrementalists do not favor large expansions because of large budget costs.

Nor does this approach hold out much hope for controlling rising costs. Medical costs are going up principally because of technological innovation, rising labor costs of hospitals, and the aging of the population. When fully insured patients confront physicians paid on a fee-for-service basis, both patient and physician have every incentive to make sure that the patient gets every available beneficial service, regardless of cost. While managed care has achieved some economies and is certain to produce more, it does not change the incentives of the key agents determining how much care is provided—fully insured patients who want everything that is beneficial, and physicians who have every incentive to make sure they get it. Governmental attempts to regulate in the teeth of private incentives almost always fail. There is no reason to think that private attempts at similar regulation will fare any better.

What this all means is that piecemeal reforms may achieve piecemeal successes in extending insurance coverage and in holding down some costs. But incrementalism will simply put off to a later date

reforms that can assure all Americans financial access to care and that promise to hold down rising health care costs.

Tax Credits

Access	Cost Control	Needless Winners And Losers	Value Congruence
A or F	D	D	A-

Providing all Americans with refundable tax credits could achieve virtually universal coverage provided that the tax credit was large enough to cover the full costs of privately purchased insurance. People would buy insurance plans that most appeal to them, pay for them individually or through employer sponsorship, and receive credits from the government sufficient to cover all of the costs of the plan. Those variants of this approach that would limit the credit to a fraction--as little as half--of the cost of typical insurance and make the purchase voluntary would almost certainly result in much narrower coverage than under current arrangements.

Furthermore, this approach has little or no potential for controlling costs. It would do little to encourage insured patients and their physicians to curtail the use of low-benefit, high-cost procedures. And the large inducements for insurers to expand sales forces and to proliferate plans would increase the already horrendous administrative costs of the current system.

Even more seriously, a generous set of tax credits would provide enormous windfalls to employers who currently finance health care for their employees. Those costs--well in excess of \$100 billion--would shift to public budgets, necessitating large increases in taxes. The pattern of tax burdens would inevitably differ from that of premiums. These gains and losses would arise from shifts in the method of financing not from the extension (or contraction) of coverage.

National Health Insurance

Access	Cost Control	Needless Winners And Losers	Value Congruence
A	A(?)	F	D

For four decades groups of elected officials and private analysts have urged that every American be provided health insurance coverage as an incident of citizenship or residence. Supporters of this approach today point to the popularity of the Canadian system among Canadians and its success in providing universal coverage. The costs of national health insurance would be paid through public budgets and financed from earmarked taxes.

Advocates of these plans have pointed out, correctly, that this approach is the hands-down winner for providing insurance coverage. They have also claimed that it holds out the maximum potential for controlling rising costs, because total costs would be subject to budgetary control. Experience in other countries suggests that central budget control can be effective in limiting the fraction of national income spent on health care. Faster economic growth abroad partly explains the slower growth in the share of national income spent on health care abroad than in the United States and one cannot be certain that the United States would realize the promise of central control for limiting spending. Still, the potential for cost control is powerful. For starters, national health insurance would obviate most of the private costs of administering the current private insurance system, which some estimate at as much as \$100 billion.

The real problem with national health insurance is the enormous disruption and redistribution it would cause. Establishing national health insurance would require shifting more than \$300 billion in financing from private payers to public budgets. Premiums, currently paid by businesses and individuals, would be zeroed out and taxes would have to be increased enough to replace them. While some attempt could be made to match up past payments with future ones, huge windfall gains and losses would inevitably ensue. The resulting pattern of burdens would almost certainly fall more on those with high incomes than under the current system. While many supporters of national health insurance see such redistribution as yet another reason to favor such an approach, complicating an already contentious controversy about health care reform with a debate about income redistribution into can only hinder passage. As a cautionary note, one should recall that tax reform became possible only when both sides agreed to make the plan as nearly neutral as possible in its effects on income distribution.

Furthermore, the shift of health care to public budgets would boost the size of the federal budget by about one-third. A major national activity would be shifted from private to public management. Short of catastrophe or revolution, it is hard to imagine the circumstances under which the American democracy, a system given to slow and incremental change, would embrace such a shift. Even the claimed administrative savings of national health insurance would be a mixed blessing if achieved quickly. They are of the same magnitude as the savings from reductions in defense spending which Congress is finding so difficult to realize because of the simple fact that one person's expense is another person's income.

***Mandatory Employer-Financed Insurance
with Public Back-up***

Access	Cost Control	Needless Winners And Losers	Value Congruence
A- to B+	A(?) or D	B	B

This approach can achieve universal coverage by assuring all workers and their families coverage through their jobs, the way most Americans get their insurance today. A public back-up plan would cover everyone else. The system rates a lower grade on access than national health insurance does because it would be notably more cumbersome.

Whether this approach holds out much promise for cost control depends sensitively on how payments to providers are managed. Simply extending the current system so that it covers everyone would not fundamentally change the incentives that have relentlessly boosted costs under the current system. In that event, this approach would rate the same low grade on cost control as incrementalism. But payments to hospitals and physicians could be controlled by regional administrative entities, subject to fixed budget limits set at the national level. New York health commissioner David Axelrod directed the development of one such proposal, and I have outlined a similar plan in *Serious and Unstable Condition*. Alternatively, the activities of multiple payers could be coordinated so that they act as a single payer.

Because this approach builds on the current system of employment-based insurance, it would not materially redistribute the costs of providing care to the currently insured employed population. A fair amount of redistribution would occur, however. Those employers who do not currently offer insurance would be required to sponsor insurance and pay premiums. Current employer sponsors would probably enjoy some savings. Some taxes would have to go up to finance the expanded public back-up plan. The amount of this redistribution of burdens would be much smaller than that under either the tax credit or the national health insurance approaches.

Although this approach is generally consistent with current institutions and arrangements, it violates current norms in mandating employer-financing of insurance. Many employers are strongly opposed to a mandate or to "play or pay" proposals for this reason. Small businesses and employers of low wage workers are particularly concerned that the added costs of insurance could be ruinous. Defenders of this approach point out that most, although not all, of the sting can be removed by transitional subsidies or gradual introduction. Even those employers who now offer insurance have mixed feelings. They would dearly like to avoid the indirect subsidies to other firms they now provide, because they pay for some of the costs of insurance for dependents of their employees some of whom work for others. But they too deplore interference with managerial autonomy.

In summary, action to reform health care financing promises important benefits. Delay will allow the problems of incomplete insurance coverage and needlessly high outlays to become worse. But no reform that promises to address these problems is free of shortcomings. Any large scale change in a system that pays for one-eighth of national production will produce large numbers of gainers and losers and will necessitate major changes in customary ways of doing business. Those who are wedded to the status quo or who stand to lose from change will resist reform. In this kind of a situation, presidential leadership is vital for effective action. I strongly support this committee and other members of Congress who are trying to educate the public on the importance and urgency of reform in health care financing. These efforts hasten the day when a sitting president or presidential candidate will carry the issue of health care financing reform to the American people and of health care financing should not be delayed.

Mr. WAXMAN. Thank you very much for that overview of the options that are available to us. But suppose we decide on no options. Suppose that we wait, we do nothing. Will the access and cost problems that our system now faces get better or worse, and I am especially interested in what you think would happen to small businesses?

Mr. AARON. I think problems are going to get worse in both dimensions, primarily because of the—some serious difficulties that are arising with respect to private insurance in the United States.

Statistical analysis is getting better and better. Even medical tests are now able to identify candidates for disease with a higher degree of probability and our accuracy is only going to improve.

That means that the ability of insurers to identify high cost customers and even high cost groups is becoming strikingly better than it has been in the past.

And given the competition in the private insurance industry, there is no way that given the forces of competition, an insurer can afford to charge a customer significantly less than the expected cost they will incur from that customer.

That means high cost groups. And there are going to be more small high cost groups because there is more variation from inexpensive to expensive among the small groups and among large ones are going to increasingly find that they cannot afford insurance.

They will find they cannot buy it if they have not previously been buying it. They will find that they have to drop insurance or that they will have to try to shift costs to employees who will then, if they have the option, reject coverage for themselves or their dependents.

On the access front, I think we face major problems, primarily in the private insurance area. On the issue of cost control, I already said in one sentence what I think the problem is. Fully insured patients meeting fee-for-service physicians are very difficult to control.

We are going to try to do so through managed care. My own appraisal of managed care, and reading of the reports on its successes and failures to date, is that it will achieve significant savings but that it will not in the end blunt the very powerful engine driving up over all costs, which arise principally from new medical technology.

So that we are going to face rising costs and that that is just going to be part of the game down the road.

Mr. WAXMAN. Suppose we come to the conclusions that we cannot raise the taxes to put into the system, to have more public funds go into it, either to subsidize those who are not going to be covered through their jobs or to take over the responsibility that has been primarily on employers in this country.

And suppose we decide that we don't want to put the burden on businesses any more than they already are, so that some people now argue that what we should do is reform the small group insurance market by restricting experienced rating, prohibiting medical underwriting, and they will argue that this will resolve one of the major problems in the health care system.

My question to you is wouldn't small group reform standing by itself do the job, or will it make things worse?

Mr. AARON. I don't think it will do either. I think it will not do the job, but it will probably make things marginally better than they are today.

It will enable some smaller employers to buy insurance who could not previously buy it. We should understand though, and I know you do, that large employers are largely self-insured and are moving increasingly in that direction.

They have been at the forefront of cost shifting to their employees, not for reasons that are reprehensible but because of pressures of competition.

I am not here to criticize or condemn, but simply to report a fact we all know. They are behaving the way any smart business executive would behave in a tough market situation.

So the pressures on rising costs are going to continue. I think we would see some small groups come into the market who are not currently in the market and buy insurance, and there would be a marginal gain.

We should remember, though, that insurers have at their disposal a remarkable arsenal of techniques other than price for screening out customers, and by way of anecdote, I will tell you one that was told to me by a manager of an HMO when the market was opened up for Medicare patients.

He said, well, we have a very good sales technique for Medicare patients. We give a dance, a long dance; and at the end of the evening, we make our sales pitch to those who are still there.

Mr. WAXMAN. Well, I am interested in your comments that it will improve marginally the situation. If we had some insurance reform, that would mean that insurance companies couldn't play some of these games that they now play, but wouldn't the costs continue to rise?

And if costs continue to rise, wouldn't that still mean that many small employers that might find insurance attractive now with these reforms still couldn't afford it?

And wouldn't it also mean that insurance would rise simply because if we eliminated medical underwriting, the costs for those small groups that are now insured would be increased to reflect that fact that groups are going to be expanded to some of those high risks and therefore the costs will go up for those who are now covered, who are not particularly as high a risk?

Mr. AARON. Your description of the facts, I think, is exactly accurate, Mr. Chairman.

I was operating with an implicit factual assumption, which may be wrong, and your interpretation could well turn out to be right.

Mine was that the primary obstacle, or a primary obstacle right now, the area of greatest price sensitivity would be on those small employers in industries where illness is particularly rife; if you are a florist, don't apply for health insurance, or dangerous, a bar or a gas station, would find insurance more affordable and would tend to come in, and that effect would exceed the one to which you made reference.

That might not be the case. And your concern that small groups now benefiting from relatively low premiums might drop out in larger numbers than those now subject to high premiums would come in, could turn out to be the case.

You are simply reshuffling an existing pie of costs among a given set of players, and if you bring in some high cost people, it is going to raise the average price of insurance.

Mr. WAXMAN. Thank you. Mr. McMillan.

Mr. McMILLAN. I think those efforts to make group coverage accessible to smaller businesses are important, and there are some good examples of that already taking place around the country, which I think the Congress might pick up on. But it is only a small piece of the problem.

And I think if I interpreted what you are saying, even if you create access for a smaller business, that leaves a whole group unaddressed that does not have a chance to participate in that.

And the same cost drivers are still in effect. And so the smaller groups that combine into a larger group are going to be faced with the same pressures that your major groups are faced with anyway, still the costs are rising in double digit numbers on an annual basis.

That is why I think it is so critical, difficult as it is, that Congress not address this simply with incremental solutions that don't get at the causes of the problem.

Ultimately we are going to have to face those if we are going to achieve anything. If you would, if you are prepared to, I would be interested in your trying to quantify some of those cost drivers.

I know it is extremely difficult to come by. Well, let's start with this. We are spending, I think it has been said, the highest per capita of any nation in the world. Probably 20 percent per capital than the next highest, which is Canada, which is supposed to have a total health care system.

Something is driving our costs, and even within that 20 percent per capita, we are not meeting a lot of needs; we know that.

Something is driving our costs. I have had the hospital administrators, for example, estimate that defensive health care costs may be as much as 20 percent of the total bill out of a hospital. And I have had that from a number of different hospital administrators, so it is not an isolated case.

I think the AMA has conceded that defensive practices may amount to something in the low teens as a percent of physicians' fees, which may be the tip of the iceberg in defensive health care costs.

But if you could, shed some light on that. You mentioned yourself technology, a technology driven system, and I think that has two aspects.

One is one more sophisticated piece of equipment that only marginally improves our capacity to deliver services over what we have in place, so you were not giving a cost-effective analysis of that incremental decision.

And the other is underutilization of the capacity that we put in place, a cost which has to be absorbed and passed on in the system.

Overhead is one that I think you haven't addressed. But let me just stop there, and if you would care to take off on cost drivers, I would be interested in what you have to say.

Mr. AARON. You have asked a lot of questions. Let me start with a couple of short observations, and in a way it is another response to Mr. Waxman.

I think the inevitable response to a small group reform of the kind that is now under consideration is that you are going to be called upon to subsidize those groups or States will be called possibly to subsidize them in order to offset the additional costs that high cost groups who come into the system would impose on others; in other words, to hold current insurance groups largely harmless.

So I think also an implicit budget cost down the road. The difference between the United States—

Mr. McMILLAN. Would that subsidy possibly come in the form of deductible premiums which are available in effect to the large group but not available—

Mr. AARON. To individuals, but to small groups now that they have deductibility at the employer level.

Mr. McMILLAN. Yes.

Mr. AARON. The difference between the United States and Canada is even larger than the number you suggest. I think it is more in the order of about 35 percent higher outlays per capita here than in Canada.

The story on malpractice is very complicated. And I cannot give you a good quantitative estimate, other than those that have been reached by people who have tried to study the effects of malpractice insurance on medical costs.

You did not mention direct premium payments, and those cannot be a major part of the story because they represent only a—less than one handful of percentage points of total medical costs in the aggregate for hospitals and physicians.

On the issue of defensive medicine, I am not sure exactly what to make of the report—the anecdotes, the stories that people tell. It exists. It has existed for a long time.

It is primarily if malpractice motivated a problem of certain specialties because malpractice litigation is of dominant importance only in a few specialties. It is not a big deal in most medical specialties in terms of cost or time spent in court.

On the issue of technological advance, that is terribly complicated. Virtually any bit of new medical equipment, major costly medical equipment that one can identify produces for some patients truly enormous benefits, and for others, negligible benefits, but the cost is the same.

The problem with the current system, which entails essentially complete insurance at the margin, at the time the patient confronts the system, and any insurance-based system will do so, is that there is no mechanism built in that tends to distinguish one from the other.

The physician knows if it is beneficial, acting as the agent for the patient, he or she should prescribe the test, the therapy, and the patient fully insured says, cost be damned, it is my kid, it is my spouse, it is me; I would like the test, I would like the therapy.

So the problem we face is not that we are bringing on stream equipment that is just generally useless. That same MRI scan that saves somebody's life—I was the beneficiary of about 6 months ago for a test in which the physician said to me, I don't think we are really going to find anything but it will provide some comfort. You are insured; aren't you?

And he sent me around to have the test. You know, he said, I know I am part of the cost control problem. He was very self-aware. There is no distinction between that and the patient who has suspicion of cerebral hemorrhage or a lesion that might be treatable and where the benefit of the test is enormous.

It holds out the potential to save lives. The problem with the current system, and indeed of many of the reform proposals, is that they don't attack that root problem.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman.

Mr. Aaron, in your first paragraph, I think you allude to, "while I have views on the directions that such reforms should take . . .", you are now the health czar, assume for a second. Tell me what those reforms are and how they should be done.

Mr. AARON. Gee, I am glad you asked that question.

My preferred option, not because I view it as the optimum health care system in a world in which I could—in which there was no history, is one that does build on the current system through some kind of a "play-or-pay" mechanism, linked to a device which I describe at length in serious and unstable condition, in which hospitals are subject to fixed budget control administered by a single financial agent for each geographical area.

The reason I think it is important to build on the current system rather than to replace it relates to this issue of income redirection.

Health care is a \$700 billion industry. Members of Congress are having considerable difficulty persuading themselves and their constituents that notwithstanding the change in world economic conditions, it would be desirable to take \$100 billion or \$50 billion out of the defense budget, money that nobody thinks brings any good to our society, apart from the ability to protect us against a threat that is no longer present.

Why is that a problem? Because those \$50 or a \$100 billion are jobs. They are facilities in communities. They are the life of communities.

If you are talking about massive redirection of health insurance costs, you are talking about shifts in outlays and in financial responsibility, at least as large as that cut in national defense outlays.

And that means not just political difficulties, as members of your communities come before you and say to you, do you know this proposal is going to cost us our hospital; it is going to mean higher taxes for me and my family.

You will know who you are affecting directly, and members of Congress, as you well know, have a hard time dealing with direct and identifiable injury resulting from policies that you may vote for.

The more of that there is, the harder politically it is to reform, and the less justifiable the reform is.

Transition is painful. It results in real losses to people and for that reason, I think it is genuinely and substantively important to minimize that if possible.

Mr. SYNAR. Let me ask you some questions. Will there have to be rationing of care under this transition?

Mr. AARON. Initially I think there will probably not be rationing of care, in the sense of denying beneficial care to people who stand to benefit from it, partly because of the savings that could be achieved from the kinds of proposals that Congressman McMillan and others have advanced.

Mr. SYNAR. Will there be discrimination between rural and urban areas?

Mr. AARON. There should not be.

Mr. SYNAR. But in moving through this transition, is it safe to assume or should we put a red flag out that there is a possibility that there will be discrimination?

Mr. AARON. Red flags will be out by every affected group. You won't have to put them out.

Mr. SYNAR. Will it affect by age or income brackets?

Mr. AARON. My answer to that is the same. I think the elderly will be well protected because they are now well insured, relative to the rest of the population.

The main concern is going to be to extend benefits to the uninsured among the nonelderly and possibly to improve benefits in certain dimensions for the elderly.

That is going to cost some money.

Mr. SYNAR. Will the system itself, the bureaucracy be so large that it will collapse on its own weight?

Mr. AARON. One of the benefits from health care financing reform should be simplification of administration. If we don't end up spending less on administration than we now do, you guys have not done your job.

Mr. SYNAR. Will there be a separate veterans and Indian health care system in this country?

Mr. AARON. I am sitting on a group of the Paralyzed Veterans of America right now addressing that specific question. My own view at this point, and it is a tentative one, is that there should be a separate veterans system to make sure that special conditions are treated, spinal cord injury notably among them, but that to the degree that veterans can be brought into the mainstream through an insurance system that covers them effectively as it covers everybody else, the need for the current VA system would be reduced.

Mr. SYNAR. One final question. Will there be price controls on medicine and medical equipment?

Mr. AARON. I believe that we will end up with limits on fees for physicians. In the end, I think we will attempt to buy cheaply to buy smart as Walter McClure and others have advised in the area of medical purchasing, but that we will not resort to price controls.

I dearly hope that we do not resort to price controls. They have never worked very well in this country or any other.

Mr. SYNAR. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Synar.

Dr. Aaron, thank you very much for your presentation. We look forward to having the members of our committee review your book and try to think through the discussion that you have presented to us.

Our next witness is Stuart Butler, director of domestic and economic policy at the Heritage Foundation.

Dr. Butler has published a number of articles on health policy issues, and we have asked him to give us his insights to the problem we face.

Dr. Butler, I want to welcome you to our hearing this morning. Your prepared remarks will be made a part of the record in full. We would like to ask if you would to limit the oral presentation to 5 minutes.

STATEMENT OF STUART M. BUTLER, DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify before you.

Senator Mitchell remarked in testimony before the House Budget Committee recently, the separation of payment for health care from the receipt of health care has been a major cause of overutilization and endemic inflation in today's system.

I would add that the current tax treatment of health care spending compounds this problem.

The exclusion for company plans certainly has helped millions of Americans to obtain medical care, but it is also grossly inequitable, giving huge tax breaks to high earners with generous company plans and nothing to most Americans without company benefits who must buy coverage themselves.

So it is little wonder that there is so much uninsurance among this latter group. Moreover, this fosters the illusion of free care remarked upon by Senator Mitchell which turns what is the key to efficiency and the rest of the economy, consumer choice, into the root of the problem in health care.

Each of the major health reform proposals tries to deal—tries to reach the goal of universal access while addressing the effects of consumer choice in the current system. In this respect the proposals can be grouped into three broad approaches.

The first is the "all payer" or national insurance model, loosely referred to as the Canadian system. In this system consumer choice ceases to determine the supply of services. Instead, government sets the overall budget; government broadly decides how health care resources will be distributed and who will receive them, and government, not the consumer, determines the value in the system by establishing treatment requirements and setting prices.

Undoubtedly these programs are popular in the countries that adopted them and they do appear to be able to keep better control of total health care spending.

But before adopting such a system, Congress should consider certain issues. Demand decisions by consumers inevitably lead to the short changes seen in the British and Canadian systems. That means there must be explicit rationing by government. Some societies are more willing to accept government rationing than others, so Congress must consider whether a system of rationing is politically sustainable in the United States.

Second, Congress must decide if it is comfortable with the idea of running one-eighth of the U.S. economy, rather than a market model. Remember that controlling prices or fees always seems to

require ever wider and ever tougher controls, as we are now seeing in Medicare and have for years in Canada.

Government monopolies or monopsonies also are not normally associated with efficiency in creating a supposedly objective system of physician worth, based on the debunked labor theory of value, as Congress did in devising RBS, ultimately would have to in my opinion in a Canadian style system would be a radical departure from the market principle that value is a subjective notion based on consumer preferences.

The second broad approach would be to make health care more like the rest of the economy, not less like it. Consumer based reform models seek to change today's perverse incentives for consumers, and use enhanced consumer choice as the primary tool to control the total costs and to achieving more efficient use of resources.

Truth in lending, Mr. Chairman, requires me to tell you that I support such a system. The consumer based models defended by Heritage and others would replace today's tax exclusion in a budget neutral way with a system of refundable tax credits in the personal code for all family health expenditures, and would require all heads of households to purchase at least a basic family package. Under this system, most tax help would go to those families who really need it to buy health care and consumers would have a much stronger incentive to choose health plans on the basis of value for money.

Such models of course also raise issues for Congress to consider. First, can consumers make wise choices in health care. Or would they, as proponents of the system argue, be able to join competing user friendly groups, such as union sponsored plans, which can make detailed consumer decisions for them.

Second, is consumer choice a potentially effective tool for cost control? In particular, would prices actually charged to consumers have to be so high to encourage efficient choices that they would be a barrier to access, or as proponents argue, would the most powerful impact of consumer use be indirect as plan organizers competing for the consumer dollar force providers to be more efficient.

The third approach, the third broad approach under consideration is the so-called play or pay proposals. In these proposals, corporations and government make supply decisions. These plans have the political attraction of seeming to build on the current system.

Again, there are several issues to consider. The first is will the public program be a financial black hole? Under the approach, employers have the right to choose what is in their best interests. The size and risk structure of the public program and its costs would be a result of these employer decisions, not government decisions.

Second, the play or pay system does seem to require powerful antidiscrimination laws, to avoid those employers offering insurance from refusing to hire people who would pose high medical costs. The Mitchell bill contains very tough antidiscrimination language. But Congress should consider whether the threat of litigation would induce most employers simply to abandon the practice of providing health insurance.

If that is the case, play or pay would be unstable as a model and would degenerate into a national insurance model.

Third, Congress needs to assess whether the political process would result in a steady expansion of the basic benefits package, raising costs for firms and for government. The experience with State mandates I ought to point out is hardly comforting in that regard. Would Congress simply be inundated with provider and labor lobbyists trying to raise the floor for benefits.

These broad observations, Mr. Chairman, I think apply to the problem as a whole. I would be very happy to elaborate on them or to answer any of your questions.

[The prepared statement of Mr. Butler follows:]

STATEMENT OF STUART M. BUTLER
THE HERITAGE FOUNDATION

Mr Chairman, my name is Stuart Butler. I am Director of Domestic and Economic Policy Studies at The Heritage Foundation. I appreciate the opportunity to testify before you today on the issue of health care reform. The following statement represents my own views, and should not be construed as representing any official position of The Heritage Foundation.

The U.S. health care system is in need of major overhaul. Americans register a lower level of satisfaction with their health system than do citizens of any other major industrialized country. But this deep dissatisfaction does not arise from the amount of money spent on health care, which is the highest in the world in total and per capita terms. Nor is it due to the quality of medicine available to the vast majority of Americans, which is among the world's best. It stems instead from four characteristics of the U.S. system: the lack of any insurance protection for millions of Americans; the widespread fear among those with insurance that their coverage will prove inadequate; the system's spiralling cost; and a plethora of controls and restrictions that irritates patients and physicians alike.

To determine how to reform the current system, we must first understand what is wrong with it.

The paradox of general abundance of good health care combined with shortages and dissatisfaction flows from perverse incentives in the system, many of which are a result of federal policies. One of the most important of these is the tax treatment of health care spending, which for the vast majority of Americans means tax relief only for company-provided benefits. This has so distorted the cost and distribution of health care that the U.S. can spend over \$700 billion each year and still have a system that nearly 90 percent of Americans believe requires major surgery.

Tax breaks for workplace benefits certainly spurred the spread of health insurance protection in recent decades. But there have been unfortunate side-effects. Effectively limiting the tax benefits to the workplace, for instance, means that if a company does not provide comprehensive benefits to employees and their dependents (a typical situation in small firms and increasingly common in financially-strapped industries), the family goes without complete insurance or pays for it in after-tax dollars.

The tax exclusion also means the biggest tax subsidy goes to higher-paid workers and executives with the most generous health benefits and at the highest tax brackets, and the smallest subsidy to the low-paid worker with inadequate benefits. It is hardly surprising, then, that the overwhelming majority of the uninsured are lower-paid but employed or are the dependents of workers.

The tax treatment of health care also fans medical inflation. With health care largely "paid for" by the employer (completely so in the case of first dollar coverage), the employee has little or no incentive to be economical when seeking services -- especially since if he does economize, the savings normally will accrue to the employer. With

patients often unconcerned about prices, hospitals and physicians experience little competitive pressure to keep costs down -- but they are encouraged to compete by providing the latest expensive technology. Thus health costs tend to rise much faster than other prices, hurting employers directly, employees indirectly (through reduced cash compensation and benefit cutbacks), and boosting prices for uninsured Americans and public programs buying health care services.

Senate Majority Leader George Mitchell drew attention to this price illusion problem when he testified recently before the House Budget Committee:

Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of the payment for health care from the receipt of health care services. That has met, to some degree, what was an unmet need; but it has, at the same time, created overutilization and a problem of attitude with respect to the quantity of health care services.

Consider this fact: In ours and every developed society, there has grown, in recent years, a very large industry based upon the simple premise that a person who can defer the payment for a good or service will purchase more of those goods or services. I confidently predict that almost everyone in this room has one or more credit cards in their pocket. It is a large and very successful industry, which operates on that simple premise: If we can defer payment, we will buy more of things. In fact, we do.

Imagine then, the effect on attitude if another person believes that they do not have to pay at all. If their attitude is, I am not paying anything for this, we readily, of course, are prepared to purchase more.

With price-consciousness significantly reduced or absent among consumers of health care, those responsible in the first instance for paying the bills resort to regulatory and bureaucratic controls to stop patients, hospitals and physicians from making the choices they have every economic incentive to make. In the private sector, that has caused insurance companies, acting as financial "gatekeepers" for employers, to impose on consumers such things as extensive paperwork requirements, demands for treatment justification and coverage limits. This not only is a major source of irritation for consumers and providers alike, but increases the overhead cost of insurance. High overhead costs occur also because, with the tax code favoring company-provided insurance over out-of-pocket expenses, consumers bill their insurance for small and regular medical costs in order to obtain tax relief. The paperwork cost of such claims is of course very high as a percentage of the cost of the services rendered.

ALTERNATIVE POLICY DIRECTIONS

Faced with today's unsatisfactory system, Congress is considering a wide range of proposals. Although these may seem to differ widely, they in fact fall into three distinct categories, in the sense that they are characterized by attempts to change the underlying

economic dynamics of the system in one of three directions.

First, there are proposals that would replace the current system with some form of "all payer" or "national insurance" model. The proposal to "import" the Canadian system is such a model. In these proposals, a government agency of some form is the single payer for health services, and imposes price controls, expenditure limits, and other direct constraints on the provider market. Second, there are proposals which try to change the perverse incentives now influencing consumers, and construct a universal system based on consumer choice. The Heritage Foundation has advanced such a proposal. The third set of proposals are often characterized as "play or pay" plans. In these, employers either must provide at least a basic package of health care to employees and their dependents, or must contribute, in the form of a tax, to a public program to cover families not covered at the place of work.

Each of these approaches raises issues and questions that need to be considered by Congress in crafting health reform legislation.

1) A Canadian-style System

An all-payer system along the lines of the Canadian system does appear to have important advantages. Like its predecessor the British National Health Service, the Canadian system is generally popular among those it serves. Such systems also appear to keep total spending down while providing universal access.

Before Congress rushes to introduce such a system in the U.S., however, there are certain things that should be considered.

First, fixing a national budget for a service while allowing free access to it inevitably leads to shortages. Shortages, and a rationing system, take the place of price as a means of regulating demand. Government allocation also becomes the instrument to determine value -- rather than the subjective views of consumers. In Britain, approximately 750,000 people, or 1.3 percent of the population, are at any time waiting to go into hospital, in some cases for many months or even years. The average wait for coronary bypass surgery in British Columbia is 6 months. In addition, the introduction rate and availability of new technology in Canada lags well behind the U.S.

Now it may well be that Americans would accept such government-determined rationing as an alternative to today's system -- although I doubt it very much. But it is important in the debate that this inherent feature of an all-payer system is not ignored.

Second, cultural and institutional differences between countries must be considered in evaluating foreign systems as models for a national health system here. It is often said, only partly in jest, that whenever a Briton sees a queue he joins it without asking what it is for. Waiting lists and rationing just are not as irritating to Britons as they are to Americans. In Canada, the national motto is "peace, order and good government." In a real sense ours is "life, liberty and the pursuit of happiness. In other words, it is not clear that the limits on care readily accepted in Canada or Britain would be acceptable here.

In addition, the day-to-day rationing by physicians and hospitals that takes place constantly in the Canadian system might be legally impossible here. As the New York Times pointed out in an April 30 article on Canada, "such delays, typical in Canada for certain costly procedures, would be considered imprudent, if not malpractice, in the United States." Thus unless there is major reform of liability laws here, it might be impossible to institute the detailed physician-imposed rationing that appears necessary if an all-payer system is to keep total costs under control.

Furthermore, demographic and lifestyle differences have to be considered. The teenage pregnancy rate in the U.S. is about 2.5 times the rate in Canada. The U.S. also has a higher percentage of elderly. And the rate of injury from violence is higher here. These and similar differences do tend to boost health care expenses in the U.S. and explain, at least in part, such things as higher infant mortality rates in the U.S. compared with Canada.

Third, it appears that limited fee controls in an all-payer system inevitably become more widespread and severe. The reason for this is that limited price controls invariably result in cost shifting to sectors that are not controlled. Thus government finds it necessary to widen controls in its effort to keep down total spending. This has certainly been the case in the Canadian system, where fee negotiations have become tougher, and where provincial governments and the national government steadily have introduced more constraints on the freedom of physicians, such as prohibitions on balanced billing and requirements on junior doctors to locate their practices in certain regions.

We have seen a similar expansion of controls in the Medicare system, the element of the U.S. system that, other than the VA system, most closely resembles a national all-payer model. After DRGs were introduced there was a spate of cost-shifting that led to an explosion in physician costs. Now the RVS system is being introduced to extend comprehensive controls to physicians.

In summary, then, while Americans might well consider all these points and still support a Canadian system, it is important that the full implications of such a system be well understood.

2) A Consumer-based System

An alternative approach would be to construct a universal system on an entirely different basis, by changing the incentives facing the consumer in such a way that consumer choice becomes the instrument for cost control, as it is in the rest of the economy. As an example of such an approach, the Heritage proposal calls for two basic steps:

1) End the link between health tax breaks and the place of work

The unlimited tax exclusion for company-provided health benefits gradually would

be phased out, and replaced with a new system of personal tax credits for family health care spending (on insurance or out-of-pocket costs). These credits would be "above-the-line." The credits also would be refundable, meaning they would constitute in effect a medical voucher for lower-income families. The credit would have nothing to do with the place of work, thus a part-time worker in corner dry cleaners would be eligible for the same system of credits as an executive with General Motors. The percentage credit would be based on a family's health spending compared with its income. As that ratio increased, so would the percentage credit. Thus low income families facing relatively high insurance and medical costs would be reimbursed for most of the cost through a refundable credit, while affluent families would obtain little or no tax relief.

2) Introduce an individual mandate

The Heritage proposal envisions a "social contract" between government and citizen. The federal government would guarantee to make it possible, through tax credits or if necessary through access to Medicaid, Medicare, or a subsidized risk pool, for every American family to afford at least a basic comprehensive package of medical care, including catastrophic insurance. In return every head of household would be required, by law, to obtain at least the basic package from an insurer or health provider.

Under this type of approach, the tax losses now incurred through the tax exclusion for company plans would be restructured in a budget-neutral manner to achieve three objectives. First, to provide the same assistance to working families with the same income and medical costs, no matter where they worked. Second, to provide more help to lower-income and sicker families than to other families. And third, by transferring the tax benefit to the personal code, to encourage families to seek the best combination of quality and price in a health plan.

A crucial aspect of this model is its method of cross-subsidy. Group plans at the place of work typically charge the same premium to enrollees who are very different insurance risks. This is how the sick are cross-subsidized by the healthy. Healthy individuals seeking to find lower-cost coverage by escaping such groups, and insurers trying to avoid high risk enrollees, lies at the heart of the adverse selection problem. Under the typical consumer-based model, however, the price of coverage would more closely reflect actual risk, and the vehicle for cross-subsidy would be the tax credits. In this sense, the method of cross subsidy in the consumer-led model is more like that in the Canadian system and very different from that prevailing today in the employment-based system.

Such a model also raises several issues.

First, can individual consumers be expected to make wise choices? Supporters of the model argue that by making the tax treatment neutral between plans offered at the place of work and plans offered elsewhere, consumers in fact would choose between sponsoring groups offering comprehensive packages, and tend to choose a group they

trusted to make detailed decisions for them if they felt unable to choose according to price and quality. Thus union-organized plans might become common, or plans provided through a farm bureau of even an organization representing individuals with particular medical conditions.

In contemplating a move towards an consumer-based model, Congress would have to consider if this scenario is likely. If such alternative "consumer-friendly" groups would not arise naturally, Congress would have to consider whether they could be artificially created or maintained by legislation -- like the early encouragement of HMOs.

Second, Congress would have to consider whether consumer choice is an adequate tool for cost control. We know in general terms that consumer choice and competition outperforms government allocation in achieving efficiency through price consciousness. But clearly there are some differences between health care and most other goods and services. The issue to consider is whether the change in incentives accomplished by the tax change would sufficiently sharpen consumer price sensitivity.

Third, is a mandate on individuals practical? Proponents of a consumer-based system suggest such enforcement mechanisms as requiring proof of family coverage during the whole year to be attached to tax forms, or requiring employers to file proof of coverage in the withholding system. Congress has to consider whether such enforcement provisions would be enough to assume sufficient rates of compliance.

3) **"Play or pay" approaches**

The third range of proposals are a hybrid between all-payer proposals and the current employer-based system. Essentially there would be two parallel systems, with employers having a simple choice: either provide coverage of at least a basic level for employees and their families, or pay a payroll tax toward a public program to cover Americans who are uninsured at the place of work.

Models of this kind, such as Senator Mitchell's "Health America" bill (S. 1227), seek to build on the current system but introduce insurance and other reforms to control costs and simplify the insurance market. For example, S. 1227 would:

- 1) Establish a federally-defined basic minimum package of health insurance benefits for all Americans.
- 2) Require employers either to purchase health insurance coverage for their workers and dependents from private insurance companies, which meets or exceeds the federally-defined minimum, or to pay a new payroll tax to fund government-provided health insurance for their workers and dependents.
- 3) Replace Medicaid with a new public assistance program providing health care coverage to all Americans lacking private, employer-provided insurance.

- 4) Establish a new set of regulations and restrictions on how private health insurers write policies and conduct business.
- 5) Create a new mechanism of government-sponsored negotiations and government-imposed regulations designed to control the quantity, quality and cost of health care services throughout the entire system.
- 6) Introduce a system of civil damages and other measures designed to prevent employers from discriminating against applicants for jobs who might pose high medical costs.

In evaluating this option, Congress needs to consider a number of issues.

First, will employers tend to reduce job openings, especially for lower-paid employees (where insurance costs likely would be high compared with cash compensation), and will the finances of the public program suffer as employers with a high cost workforce simply pay the tax and shift the insurance cost to the government?

As the CBO points out in its July analysis of health reform options, a mandate on employers will induce many firms to lay off workers and reduce hiring as labor costs rise. Proponents of play or pay maintain that this effect will be modest, as will the effect of shifting by employers.

However, such calculations will be affected by the response of government to the incentive for employers who "play" to discriminate against job applicants who pose potentially high medical costs for the firm. Congress and the courts likely will have to apply very strong and complex antidiscrimination measures if this is to be prevented. The Mitchell bill contains very strong provisions allowing for heavy fines and permitting damage claims by individuals proving discrimination. Faced with the prospect of litigation, many firms may choose to pay the tax and avoid that risk. Other large firms might try to avoid litigation by pressing Congress to end the employer-based system and enact a full national health system. Either way it may be that a play or pay system in fact is politically and economically unstable, and would evolve quickly into a tax-financed national health system.

Second, Congress must consider if cost controls in the public system can be effective without producing the shortages and other problems associated with an all-payer approach. Medicare, for example, has even more stringent price controls than envisioned in S.1227, and yet has not held down costs. Similarly, business efforts to control costs have been disappointing. Thus it may be that fee controls and expenditure limits will have to become so pervasive and tough that play or pay becomes almost indistinguishable from an all-payer system.

Third, Congress needs to assess whether the political process will tend to cause the basic benefits package to expand, making it harder for firms -- and the government -- to control total costs. Today, firms can at least negotiate with employees over their benefits and can sometimes insist on reasonable cost savings. But with a federal mandate, the incentive for organized labor will be to come to Congress to obtain more generous benefits if unions cannot win them at the bargaining table. Providers, too, will come to Washington to press for more services to be added to the package, just as they have at the state level through insurance mandates.

In conclusion, the three broad categories of proposals envision three different dynamics of reform, and each raise complex issues. If Congress is to achieve a universal system, with reasonable access for all Americans at an acceptable cost, it must debate these issues thoroughly.

Mr. WAXMAN. Thank you very much, Dr. Butler. Let me ask you the same question I asked Dr. Aaron a minute ago.

Suppose we do nothing, we don't act on any kind of reform. What are the consequences for those workers who now have coverage through their employers and for those who don't.

Mr. BUTLER. I think broadly I would agree with Dr. Aaron on that, and I would just emphasize that I think the problem of uninsurance would probably get worse, both because of the tendency to drop coverage or to substantially increase deductibles and other elements of costs by current procedures.

I think there would also be a growing tendency of friction as we see today between organized labor and management, as management tries to bring down costs, meanwhile, employees have little incentive to accept this.

I think we would see, as others have said, a worsening of the situations. That is why I agree we need a formal system, it is broke.

Mr. WAXMAN. In your testimony you suggest a "pay-or-play" approach is politically or economically unstable, and it would evolve quickly into a tax-financed national health system. I can see that is an interesting idea. There are other witnesses today that aren't going to be quite so sure that is the result.

Why do you think this approach, which is intended to build upon and repair the current system, would lead to a national health plan?

Mr. BUTLER. I can see the attraction. There is certainly, in broad terms, trying to build on what you have making sense.

As I emphasized, I think you are going to see employers, if you are adversely selecting against the government, if they feel they are better off by shifting the costs to government, they will do so.

Mr. WAXMAN. That might depend, however, on the amount of money for a payroll tax.

Mr. BUTLER. Yes, it would.

I think the tendency is—I think the overlooked point that I tried to bring out in my testimony is the question of litigation, because certainly there would be a powerful incentive on employers to avoid hiring people who pose very high medical costs, themselves and their family. If that is the case, it seems to me, government and the courts are going to look at ways to try to stop this from happening. That is going to lead to the kind of litigation which would make the kind of litigation under discussion in the Civil Rights Act child's play.

I think the ultimate effect is very large employers would shift their personnel to the public system.

Mr. WAXMAN. The Pepper Commission recommended a "pay-or-play" system. That system also recommended an insurance form that would prevent companies from trying to underwrite the risk and trying to exclude people.

I find it hard to understand your last point if you think this is going to be litigation because there is an incentive for small businesses not to hire people who offer potential risk.

Mr. BUTLER. I am not sure they will sufficiently deal with that issue. They raise other problems, as Dr. Aaron pointed out. I don't think they will be that foolproof, if you like.

All you really need is an employer to feel there is a significant risk of what could be very expensive litigation, based on a discrimination suit, for there to be a very large shifting of employees into that public system. I think that is the pattern—

Mr. WAXMAN. That is the major reason you think there will be a move toward a public system?

Mr. BUTLER. I think it is a very significant reason, because it introduces an uncertainty of potential costs. An employer can look at what he is paying today and what he projects to pay, and he can compare that with a payroll tax.

It is much harder for him to compare it to a litigation. So, therefore, I think that even when the comparison of payroll costs and existing insurance costs seem to favor that insurance, this other factor will be a powerful inducement to avoid potentially very large risk by shifting that into public system.

Mr. WAXMAN. How successful do you think Dr. Aaron's idea about negotiations with providers to contain costs would be?

Mr. BUTLER. In a "pay-or-play" system?

Mr. WAXMAN. Yes.

Mr. BUTLER. I think he is over optimistic.

I think in answer to some of the questions by Mr. Synar, that I do feel inevitably that system has to impose fee controls.

It does have to impose very tight budgets on hospitals, and so forth; it has to.

If it does so, it seems to me, that it has all the—if you like—it has many of the problems with an all pay or national system, yet it retains this facade, in my opinion, of an employer-based system; a system where so many of the basic rules and, so forth, are set by another agency.

Mr. WAXMAN. Why do you think your consumer choice idea would lead to control of costs if this consumer really isn't in a bargaining position with the provider who will decide the demand for the service?

Mr. BUTLER. Two reasons: First of all, moving to a consumer-based system at least they introduce the notion of the consumer having some incentive to consider costs benefit—which is clearly not the case today.

The second thing, I agree if a consumer-based system consisted of the consumer—it is like bargaining with each physician when he is on the operating table. I think in a consumer-based system, there would be a fact—be a tendency for individual consumers to accept very tight limits on their detailed choice for physicians.

I think Americans would drift in that direction. I think the reason they are attracted to the Canadian system, they place a high regard on simplicity and no bills; that, I think, would be something that under a consumer-based system would occur naturally and, therefore, with less opposition than trying to impose it through an employer-based system or some kind of Canadian-style system.

Mr. WAXMAN. Thank you.

Mr. McMillan.

Mr. McMILLAN. Dr. Butler, have you given a lot of attention to the cost drivers in the system?

Mr. BUTLER. Yes, and there are many.

I have emphasized that in my testimony and elsewhere, that while clearly now you do have a very different kind of market in health care, certainly the providers of health care have an unusual position to raise costs in the system and indeed, a duty to. Simply the insurance system has a very different effect in the system that insurance generally does elsewhere, where if you use your insurance, it raises your own premiums.

I think the attitude of consumer generally in the system adds to all these other problems and compounds them. If you are going to get some kind of a solution to that sort of a Canadian-type of system that really moves consumer choice as an engine of any kind of supply in the system, if—short of that, you are going to have to have either an attempt to try and introduce greater consumer sensitivity, which is what I propose, or a very elaborate system of trying to really counter consumer choice decisions made by individual consumers, which is really what you have today.

I believe you would have it in a “pay-or-play” system.

Mr. McMILLAN. I am not an advocate of the Canadian approach, but the Canadian approach does get at the issue of defensive practices because of their tort system. On the question of technology, there are more CT scans in San Francisco than in Canada. You can go on and on.

They ration services and all of those give them a measure of control.

You are advocating an intriguing approach that I think has a lot of merit behind it, but I don't see in it the capacity for the system to address the cost drivers, so even though you empower the consumer of whatever income to provide a—or to at least be assisted by the government through either credits or actually a direct payment to enable them to buy that system, it does enhance their capacity to exercise a discipline over a market system, as I see it.

Mr. BUTLER. Well, really there isn't enough time in these hearings to go into great detail how we would do that.

I would be happy to provide you with more information on how we do believe that system would work.

The underlying point I would try to make, whatever you do, short of a Canadian system, unless you introduce at least some incentive for consumers to take cost and benefit into account, you are sort of running against the tide with any other kind of proposal that seeks to build on the current system, and so forth, and that is a point I would make very, very strongly.

Maybe you feel, given the choice between a consumer-lead system and a Canadian system, members of Congress may feel a Canadian system is preferable. I think it is this area in the middle that is the problem where you try to build on the current system would fundamentally address the question: Why would the consumer freely choose to do anything which takes cost benefit into account in a normal way?

Unless you address that, you are going to run into continuing problems, and that is why I think the “pay-or-play” system is inherently unstable as a solution to the problem.

Mr. McMILLAN. In your approach I know you haven't had time to lay it out, but you basically are proposing a substitution for the existing government-reimbursement plan or maybe retain them—

then you take, in effect, the tax credit system, the revenue foregone and spread that over the entire population.

Mr. BUTLER. In a different structure.

Mr. McMILLAN. But you don't change the total amount of that credit.

Mr. BUTLER. You could or you couldn't.

Mr. McMILLAN. You don't take a position on that?

Mr. BUTLER. We have argued you take the existing \$48 to \$50 billion of that revenue loss and restructure that in the form of tax credits. The current tax exclusion gives enormous benefits in higher earnings, and with very generous company plans, and literally nothing to millions of Americans who are not insured at their place of work. I am suggesting changing that into a credit system available to the personnel code.

I would point out at least people who work for small firms, rather than trying to build a system for small business insurance, it would allow employees of those firms to join another major group, union types of groups, or another employer might indeed take those people on.

Mr. McMILLAN. Or an individual who is not part of a group.

Mr. BUTLER. It is possible. That would be part of the market.

Mr. McMILLAN. Thank you very much.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

We all have a tendency to postpone—I mean to avoid postponement of adjournment and consumer resources, which means we have a choice of providing the purchase of a premium on a health policy and expending that money for what we perceive to be an important thing in our life—vacation, maybe a second automobile, may be something outside the health field.

I think there is a tendency on human nature, particularly in a country that emphasizes consumption, so much as America, to put off buying that policy.

Would you comment on the policy option that maybe we will be considering in this country, first off to say that it is the policy of the U.S. Government that every individual should purchase their own health insurance or provide for their own health coverage, that is a policy, not a mandate.

And, second, to have a mandate that every citizen must perform that duty, but then we deal with the issue of how to fulfill the mandate, and on that point I am talking about the arbitrarily fixing a percentage, just like we provide for our retirement by social security, we are required by law to provide for coverage for health insurance through a mandate of a deduction from our salary that would flow into an IRA Health Service Act for which to pay for health services or medical expenses.

Would you comment on those?

Mr. BUTLER. I certainly subscribe to the view—I would call it a mandate on heads of households to obtain a basic package, in particular for their dependents.

I would be more concerned about dependents' children than I would even an adult deciding to take a risk. Certainly, unless you do that or make it freely accessible to everybody, you would,

indeed, get people who at the end of the month or end of the year would take a chance, and many do today.

With regard to how you do that, and what would be included, I think you—one way or the other, Congress or some legislature has to make a decision as to what we think as a society is a basic minimum the people ought to have for themselves and particularly for their dependents, and that is a big question, and I think that is what the legislature is for to make those broad decisions.

As far as an IRA-style account, I think that is a useful device. I support the basic idea of putting the money aside in some kind of taxfree account in order to defer enormous expenditures in the health care area.

I am not sure it would be a sufficient remedy to the current situation, however, both, I think some people simply wouldn't do that.

The kind of tax preference you would provide to that might be a very limited incentive to people on low incomes.

So while I don't disagree with it as an approach, I don't think it is a comprehensive approach to a fundamental reform of the system.

Mr. DANNEMEYER. I had occasion a week or so ago in my area of southern California to interview a manager of a small clinic that treats people across the age spectrum, including Medicare patients, and she just related to me that since the system of participating, nonparticipating began 3 or 4 years ago this particular clinic is participating. And since that process began the clinic, when a consumer under the Medicare program comes in to consume a health service, they are not able to require that that recipient pay anything at the time of receiving the service.

They must wait until after Medicare reimburses them weeks, months later before they then can bill that patient for the patient's share, which is, I believe, some portion of 80 percent that the Medicare allows.

When you look at the numbers Medicare is really reimbursing a physician under Medicare for less than a plumber charges to fix our plumbing. And as a result, this particular facility has made the policy decision they are not going to take on any new Medicare patients.

One of the options that this manager suggested that be adopted would be a requirement that when a Medicare beneficiary comes to a facility to consume a doctor's call, that the Medicare beneficiary be required to pay some portion at the point of consumption of the service, upfront, as some means of discipline of the overconsumption.

In this instance, they reported under the prior system, when the Medicare beneficiary had to pay a small portion at the time of the consumption of the service, they came in three or four times a month.

Now when they don't have to pay anything at the time they consume the service, they come in two or three times a week. Can you comment on that?

Mr. BUTLER. I think clearly in the Medicare system and other similar systems around the world where the government is underwriting, if you like, part of the costs, there are these kinds of tendencies in that system, and they certainly do effect physician deci-

sions, hospitals decisions and hospital inclination to take on those kinds of patients.

It seems to me, there are really two ways of approaching that. One is as you remarked, to say, well, let us now try to make the person who is eligible under the government program, make decisions that are more like people in the private sector, which is what they are suggesting. An alternative is to expand the kind of rules and regulations in the government system to the private sector so the clinic is not in a position to say, I will, in fact, stop servicing these people and choose these people or to shift costs between the two groups.

It seems to me those are the two options that you have and it is a question of choosing one or the other. I think as I emphasized that the tendency will be, if you have any kind of substantial government system, as in a "pay-or-play" system for the—the tendency will be for government to extend its rules into the private sector. Simply to stop this kind of thing you are referring to, either not servicing groups or shifting costs.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Dr. Butler, we thank you very much.

Our next panel is made up of different members who have each introduced their comprehensive health care reform bills. While these bills differ, they all share a common approach.

They would replace our current employment-based system with a public insurance program, either at the State or Federal level.

We have our colleague from the Energy and Commerce Committee, Representative Markey, chairman of the Subcommittee on Telecommunications and Finance. He is the author of H.R. 2297, the Health State Reform Opportunity Act of 1991.

We also have our colleague from California, Representative Stark, who chairs the Health Subcommittee of the of the Committee on Ways and Means. He is the author of H.R. 650, the Medicaid Act of 1991.

The gentleman from Florida, Representative Gibbons chairs the Subcommittee on Trade of the Committee on Ways and Means. Author of H.R. 1777, Medicare Universal Coverage Expansion Act of 1991.

The gentleman from Illinois, Representative Russo, is the author of H.R. 1300, Universal Health Care Act of 1991. This bill has 49 cosponsors, including 6 from the Committee on Energy and Commerce. Ms. Collins, Mr. Markey, Mr. Towns, Mr. Studds, Mr. Scheuer, and Mr. Swift.

The gentlewoman from Ohio, Mrs. Oakar, the author of H.R. 8, Claude Pepper Comprehensive Health Care Act.

Finally, the gentleman from Vermont, Mr. Sanders, is the author of H.R. 2530, National Health Care and Cost Containment Act.

We are pleased to welcome you all. As I understand it, Representative Gibbons is going to be with us later. Let's hear from Mr. Stark first.

Let me indicate to all of you your prepared statements will be in the record in full. We will, however, be required to limit your presentation to no more than 5 minutes.

STATEMENTS OF HON. FORTNEY PETE STARK, (CALIFORNIA); HON. EDWARD J. MARKEY (MASSACHUSETTS); HON. MARTY RUSSO (ILLINOIS); HON. MARY ROSE OAKAR (OHIO); HON. BERNIE SANDERS (VERMONT); AND HON. SAM GIBBONS (FLORIDA), ALL REPRESENTATIVES IN CONGRESS

Mr. STARK. Thank you, Mr. Chairman.

I know it is your tradition, as it is in ours, to let members of the subcommittee lead off here, and I had committed to one of our colleagues to attend one of those television things where they rent the time in advance.

I dare not be late to arrive at B-318, and I appreciate your accommodating me by letting me lead off this distinguished panel.

I want to thank the chairman for focusing more attention on the problem of the American health care system which has the dubious accomplishment of leaving 50 to 60 million Americans without adequate protection and ringing up costs in excess of \$1.5 trillion by the year 2000.

If, in fact, there can be no other reason for you other than your social conscience to see that we take care of the uninsured in this country and, indeed, contain costs, look at it this way: The committee—subcommittee which I chair, and the vice chair, Mr. Russo, by the year 2000, would have a budget under our control slightly in excess of the Pentagon budget.

We look forward to that, but I am sure that ought to bring to the hearts of many of our colleagues and maybe push them on to do something else.

I have another proposal for getting something done. It appears that the administration has taken a position that can best be summarized as abstinence, celibacy, exercise and prayer as a way to characterize these 50 million insured.

While that may be popular in some quarters, it is not popular in my district. I would suggest we could all pass a bill which says none of us would have health insurance, no member of Congress would have health insurance, nor our staff, until such time as we completed work on this legislation, and I rather suspect we would change that 100 days into a very few days because we would then realize the urgency many Americans feel.

Generally, they are healthy. They are worried about a financial catastrophe.

I think we could all agree there are three basic rights in this country, and I repeated them over and over, but the first one is every resident, as a matter of right, ought to have health care. That isn't a constitutional provision now except for prisoners, and as I always said, as the gentleman from California will appreciate, the only people entitled under the Constitution to medical care are people in the slammer.

So if you don't have insurance, speed on the freeway in Los Angeles, and hit the cop who stopped you, you will need more medical care than you ever imagined.

My second, every provider ought to have reasonable—not necessarily desired, but reasonable compensation for their services.

And, third, we all ought to pay for it according to our ability to pay. That means a progressive system.

The very poor should pay nothing, and those of us who enjoy adequate salaries as members of Congress do, should pay substantial amounts for the benefits which we derive from health and insurance.

A couple of things that I would say and then quickly get to my bill: I don't think you are going to change the delivery system, politically speaking.

I heard the previous witness and one of the members of the distinguished subcommittee inquire as to how we could hold down individual's purchase of medical care.

Individuals don't purchase medical care. They like doctors as a phenomenon, but they don't want to go see them.

I would suggest to any of my colleagues here, when is the time they spent a satisfactory afternoon shopping around for a test that no one told them they needed?

We don't like to go and be stuck with needles or other instruments. We don't like to spend time in hospitals and rarely do you find someone who voluntarily overutilizes the medical system, unless they are very, very ill and in pain.

So let's not try and change the delivery system.

The one system we probably must change is the payment system and there I would challenge, as I often do, the members of the subcommittee, the distinguished panel, most of us can't define what our medical benefits are. We don't know within 80 percent accuracy how many dollars we get in the hospital; are kids covered; how many mental health benefits we get; does it pay for pharmaceuticals in the hospital or after the hospital. Vaguely, we know we are covered, but we don't know the specifics. That is equally true among our citizens.

They are not concerned. They are only concerned they have coverage. What I have suggested basically is to take the system which we all know best, and that is Medicare, the most efficient, cost-effective popular insurance program in the United States, bar none, and expand that to cover all Americans as a basic coverage and allow, in effect, the private insurance industry to fill in with a supplemental program which covers the deductibles and copays. This could cost an extra \$60 billion a year if you made every person covered. You will hear about lots of programs that are less comprehensive and you will hear about some that are more.

I just suggest to the members of the panel, use Medicare as a guide. You want to cut benefits from where Medicare is. I can tell you how much you can save. If you want to expand on them, you can find out very easy how much extra it will cost.

You'll hear that the doctors don't get enough but they are all practicing. The hospitals aren't all going broke. They all say they are, but they are not. I use that as the baseline and let's expand on that and figure out how we can bring those 50 to 60 million Americans into this system.

I, again, want to thank the chairman for his work and look forward to working with this panel and the subcommittee in the future.

Mr. WAXMAN. Thank you, Mr. Stark. I know you have to leave. [The prepared statement of Mr. Stark follows:]

PREPARED STATEMENT OF HON. PETE STARK

The American health care system is currently right on track to achieve the dubious accomplishments of leaving fifty million Americans without health protection while ringing up costs in excess of \$1.5 trillion by the year 2000.

We can stand back and do nothing, or we can act to assure that these outcomes do not come to pass.

Access to health care should be a basic right of every American. Unfortunately, it appears that we slip further away from assuring this right every year.

Almost thirty-four million Americans currently lack health insurance, and another seven to ten million Americans are covered by inadequate plans. As many as sixty-five million lack health insurance at some point during the year.

And while more and more Americans find themselves without health insurance, the system keeps spending more and more and more dollars, as if there were no limits. If we don't act to contain our health care costs, we will bankrupt our industries and price our products out of the international marketplace.

A national strategy is necessary to provide all Americans basic and affordable health care. Unfortunately, other approaches, including the employment-based plan recommended by the Pepper Commission, would not be truly comprehensive. Only a single payer plan under public auspices can assure every American a basic level of health services.

For example, under an employment-based plan, children may be particularly vulnerable. Changing family patterns create equity problems with employer-based plans and often leave children or spouses without the coverage they need. Only a public plan can assure that all children are covered and that payment on their behalf is shared equitably.

Part-time and seasonal workers may also fall through the cracks in an employment-based system. It is unclear how such an employment-based system would help those individuals who change jobs, are employed by more than one employer, or are unemployed for some period during a year.

A national plan is also critical for cost containment. Through a single national plan, operated by the Federal government, it is possible to build upon the fiscal discipline that we have achieved in Medicare. An employer mandate approach would continue the ineffective patchwork approach to controlling costs of the current system.

Because I am convinced that a national strategy is necessary to provide all Americans basic health services and implement meaningful cost containment strategies, I have introduced the MediPlan Act of 1991 (H.R. 650) to provide publicly-financed health insurance to every American.

The MediPlan Act of 1991 will assure vital health insurance protection to every American. Its enactment would make real every American's basic right to high-quality health services and would control skyrocketing health care costs. All residents of the United States, rich or poor, would be enrolled in MediPlan and eligible for health benefits.

Enactment of MediPlan will achieve an important goal of the American people -- universal access to health care. And it will do so in a responsible, cost-effective manner which builds upon the proven strategies of Medicare in order to control costs.

MediPlan's basic benefits would be similar to those currently provided to the elderly by Medicare. In addition, MediPlan would cover all children and all pregnant women without payment of a premium and without copayments or deductibles. Benefits would include needed pre-natal, labor and delivery, and preventive well-child care, including immunizations. MediPlan would also provide additional, essential benefits, such as prescription drug coverage, for low income Americans, who would also not pay premiums, copayments or deductibles.

MediPlan is not based upon ideas borrowed from another country. Its basic design was developed by the Congress and the Kennedy Administration in the early 1960s. In fact, at the time Medicare was developed, many believed that it would be expanded to phase in coverage of other groups.

It is also true that MediPlan does not require the creation of a new system from scratch. All of the administrative mechanisms already exist.

MediPlan also provides for responsible, workable cost containment. Through the use of Medicare's DRG-based prospective payment system (PPS) for hospitals and through volume performance standards and resource-based relative value scale (RBRVS) for physicians, MediPlan builds its cost containment strategy on the only proven cost containment system. It is important to recognize that Medicare is the most successful health insurance program in this country.

This is somewhat different from our usual view of Medicare. The more common view, expressed frequently during reconciliation debates, casts Medicare in the role of a government program whose costs are out of control. The truth is that, when compared to other insurance plans, Medicare is a virtual model of effectiveness and efficiency.

We have done a better job of providing benefits, assuring access to care, and controlling costs than any other public or private health insurance plan in this country. This is a record that can, and should, be built upon as the basis of a program of universal access for all Americans, and that is what I propose to do through MediPlan.

MediPlan is budget-neutral; the proposed legislation raises the revenue necessary to cover its cost. Through a combination of employer and employee-paid premiums plus a new tax on gross income, MediPlan provides a blueprint of how comprehensive health benefits for every American could be financed.

To finance the basic health benefits, every person with income above the poverty line would pay their share of the MediPlan premium (the total premium is about \$1,000/person) through the income tax system. Every employer would pay eighty percent of the MediPlan premium on behalf of each working American through a payroll tax of about \$.40 per hour to a maximum of \$800/year per employee. Thus, each full-time worker would be responsible for \$200 of the annual premium.

Low-income persons would not pay the individual's share of the MediPlan premium. For individuals with annual incomes between \$8,000 and \$16,000 and married couples with incomes between \$16,000 and \$32,000, the share of the MediPlan premium would be phased in.

MediPlan requires \$65 billion in revenues beyond the payment of the MediPlan premium to support health insurance for children, pregnant women, and low-income persons.

To finance the \$65 billion, revenues would be raised under MediPlan through a two percent tax on gross income, including tax-exempt income, deferred income and other forms of income not currently subject to taxation. Individuals with incomes below 200 percent of the poverty level would be exempt from the tax. All revenues from the MediPlan income tax would be paid into the MediPlan Trust Fund.

MediPlan's health care benefits would provide a true health care safety net for every American. I suspect that most will embrace the benefits included in this bill, but not support the proposed taxes necessary to fund the benefits.

To talk about the benefits without considering the costs and how to pay for benefits is to mislead the American people. I would urge those who object to the financing proposal to offer one of their own, or suggest areas where benefits of the program should be reduced.

I hope that my plan will move the debate forward, so that the 102nd Congress can enact the major changes the country so desperately needs. I look forward to working with my colleagues on the Committee on Energy and Commerce to achieve that goal.

Mr. WAXMAN. Are there any questions that any members of the subcommittee feel they have to ask Mr. Stark before he leaves?

Mr. DANNEMEYER. I would like to ask Mr. Stark a question, if I may.

On your third point you mentioned that the poor should not be required to pay anything. Determining what portion a poor person has to pay is not easy.

I accept the concept our society being humanitarian must provide for health care, but then comes that delicate question. When does an individual with modest resources make a decision to make optional purchases and avoid the payment of health care?

Mr. STARK. I think we have to define that.

Mr. DANNEMEYER. And place the burden on his fellow citizens? That is a delicate question. Wouldn't it make some sense an individual no matter how poor they are if they work some place they have to take a small portion of their wages and put it aside for the payment of health care expenses when they come along?

Mr. STARK. I think anybody who is employed and has income, say, above the poverty level, and I suppose that is—\$10,000, ought to put something aside out of each hourly stipend, so that makes sense, sure.

But for many people who are employed part-time that might be not a very big amount. I would anticipate that working people might very well have some small portion withheld. Where that level is set would be determined, obviously, as we determine it now for Medicare or other poverty programs.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Mr. Stark, we appreciate your testimony.

Mr. WAXMAN. Mr. Markey, we want to hear from you next.

STATEMENT OF HON. EDWARD J. MARKEY

Mr. MARKEY. I thank the chairman very much for granting me the indulgence of testifying before you today.

And it is the first time in 15 years on the Energy and Commerce Committee that I have appeared as a witness before the Health Subcommittee. But it has come to my attention that—it would be difficult to ignore that over the last 15 years, and more I am sure, the gentleman from California has been an advocate for a comprehensive national health insurance plan. Unfortunately, he suffers from that old problem that liberals are usually right, but too soon. And at this particular point in our country's history I think more and more people are coming around to the approach which the chairman has advocated all these years, which is we do need a comprehensive national health insurance program.

Now, on the one hand there is pay or play, which the chairman advocates. On the other hand, there is the single-payer approach, which the gentleman from Illinois supports.

I am a cosponsor of the Russo legislation. Nonetheless, I would like to make it quite clear at this point, Mr. Chairman, that any legislation of a comprehensive nature which this subcommittee produces will have my wholehearted support, as the last 15 years.

Nonetheless, I think the gentleman from Illinois has very many poor ingredients in the formula which he has constructed, which does deserve the full consideration of the committee, and as a co-sponsor, I support and hope it will be adopted.

Let me say, however, the legislation which I am here to speak about this morning deals with the observation of Justice Brandeis, which is the States are the laboratories of democracy and as a result we should, in fact, be dealing with the opportunities which we can give to the States which will allow them to develop in their own individual ways, approaches to deal with the health care crisis which is upon our country.

Is legislation, H.R. 2297, which will help to remove the obstacles that are keeping States from enacting their own comprehensive cost-effective solutions to the health care crisis, it will assist the States who will no longer have to wait for the Federal Government to act by providing them with Federal waivers that are a critical component to the success of their plan.

To date, no State has yet adopted a single-payer approach, although 20 States are considering proposals that could only be implemented if legislation becomes law.

H.R. 2297 involves two simple concepts. First, it provides firm guidance to States to involve business and consumer purchases of health insurance to design a unified Statewide health care policy that guarantees universal access to necessary health services, including mental health; reduces health care costs by increasing efficiency and reducing paperwork; makes the health care system more user-friendly and sets a uniform budgetary system and provides equitable program funding; and, second, the legislation would provide States which would enact programs meeting those rigorous criteria with a Federal waiver to allow them to implement their universal health care system without losing their share of Medicare or Medicaid dollars.

Simply put, the bill says that States that are able to reach a consensus on an approach that will cut costs, provide universal access and assure quality health care should not face a Federal roadblock. If they can figure out how to be more efficient, we should not prevent them from doing so.

The bottom line, the Federal Government should no longer stand in the way of States. This point is brought home when we look at the widely acclaimed health care system of Canada. The Canadian health care system began in Saskatchewan. One province took the initiative and implemented a single-payer system whose success was so overwhelming it promoted the Canadians into action which resulted in their current health care system.

My own State is one of the 20 States currently considering single-payer health legislation. There are 19 others. I believe if we acted wisely and in an expeditious fashion, along with appropriations of approximately \$30 million, a one-time-only planning grant authorization, that we could construct year's strategy which would allow for various States' approaches to begin the opportunity to flower.

In my belief, create the impetus that would ultimately result in a comprehensive national health care strategy being adopted. I thank you.

Mr. WAXMAN. Thank you very much, Mr. Markey, for your presentation.

[The prepared statement of Mr. Markey follows:]

STATEMENT OF HON. EDWARD J. MARKEY

Mr. Chairman, thank you for holding this hearing today on national health care legislation, which, as we all are well aware, is one of the most critical issues facing America today. I also thank you for inviting me to testify today on H.R. 2297, the State Health Reform Opportunity Act of 1991, legislation I have introduced in an effort to move the health care debate forward.

Mr. Chairman, there is no need for me to further outline the overwhelming crisis we are facing in our health care system. The double doors to quality health care—access and affordability—are closed and locked for too many Americans to let this issue slide another day. We all now know that millions are uninsured and that, with so many working Americans without health insurance, our current employer-based system of obtaining health insurance is not working. We must stop treating health care as a privilege, and start treating it as a right of every American.

I appreciate the leadership of my colleagues on this important issue, particularly that of the distinguished Chair of this subcommittee. You have been instrumental in pushing for reforms to address the well-known problems of our health care system.

I support a national solution to solve our national health care crisis. I am a co-sponsor and strong supporter of legislation introduced by my friend and colleague, Representative Marty Russo, who is also testifying here today. The Russo bill would implement a single-payer national health care plan which would cut costs, and ensure universal access through a single publicly administered plan.

Our solutions to the Nation's health care crisis must be comprehensive and they promise to take time. Incremental band-aid solutions will not suffice. Inside the beltway, our response to the Nation's call for reform will be slower than those outside the beltway demand. The response of the White House is predictably lacking in leadership. As Mr. Bush continues to denounce every proposal the Democrats come up with, the administration's response typically pays only lip service to the issue, and a comprehensive solution is predictably absent.

Outside the beltway, however, States are moving forward quickly in the health care debate. We should remind ourselves of Justice Brandeis' observation . . . that in our Federal system, States serve as "the laboratories of Democracy".

This is why I have introduced H.R. 2297, the State health reform subcommittee. You have been instrumental in pushing for reforms to address the well-known problems of our health care system.

I support a national solution to solve our national health care crisis. I am a co-sponsor and strong supporter of legislation introduced by my friend and colleague, Representative Marty Russo, who is also testifying here today, the Russo bill would implement a single-payer national health care plan which would cut costs, and ensure universal access through a single publicly administered plan.

Our solutions to the Nation's health care crisis must be comprehensive and they promise to take time. Incremental bandaid solutions will not suffice. Inside the beltway, our response to the Nation's call for reform will be slower than those outside the beltway demand. The response of the White House is predictably lacking in leadership. As Mr. Bush continues to denounce every proposal the Democrats come up with, the administration's response typically pays only lip service to the issue, and a comprehensive solution is predictably absent.

Outside the beltway, however, States are moving forward quickly in the health care debate. We should remind ourselves of Justice Brandeis' observation that in our Federal system, States serve as "the laboratories of democracy".

This is why I have introduced H.R. 2297, the State Health Reform Opportunity Act. This legislation will help remove the obstacles that are keeping States from enacting their own comprehensive, cost-effective solutions to the health care crisis. It will assist States who will no longer wait for the Federal Government to act by providing them with a Federal waiver that is a critical component to the success of their plan.

To date, no State has yet adopted a single-payer approach, although 20 States are considering proposals that could only be implemented if my legislation becomes law.

H.R. 2297 involves two simple concepts. First, it provides firm guidance to States to involve business and consumer purchasers of health insurance to design a unified, statewide health care policy that: (1) guarantees universal access to necessary health services, (2) reduces health care costs by increasing efficiency and reducing

paperwork, (3) makes the health care system more "user friendly", (4) sets a uniform budgetary system, and (5) provides equitable program funding.

Second, H.R. 2297 would provide States which enact programs meeting those rigorous criteria with a Federal waiver to allow them to implement their universal health care system without losing their share of Federal Medicare and Medicaid dollars. Simply put, my bill says that States that are able to reach a consensus on an approach which will cut costs, provide universal access, and assure quality health care should not face a Federal roadblock. If they can figure out how to be more efficient in spending Federal dollars for those programs, then we should not prevent them from doing so.

The bottom line is that the Federal Government should no longer stand in the way of States that enact single-payer legislation to solve their health care problems. This point is brought home when we look at the widely acclaimed health care system of Canada. The Canadian health care system began in one province's laboratory—Saskatchewan. One province took the initiative and implemented a single payer system whose success was so overwhelming that it prompted the Canadians into action which resulted in their current national health care system.

My own State of Massachusetts is one of the twenty States that is currently considering single-payer health care legislation that could qualify for a waiver under H.R. 2297. Other States include the home State of the chairman of this subcommittee—California, as well as Illinois, Michigan, Minnesota, Oklahoma and New York to name a few. Most of those State bills actually include language requiring State agencies to request Federal waivers by a certain date.

Mr. Chairman, the path to winning a Federal waiver should not be easy. Any State going down that path will face a long and arduous process which will involve achieving consensus from a wide variety of interests. However, the debate in a number of States is moving quickly and legislation may be enacted in the next year or two. Those pioneer States that move more quickly than the Federal Government, but achieve a consensus that stays within specific Federal guidelines outlined in my bill, should be given the opportunity to serve as our Nation's laboratories of Democracy. Additionally, the revenue impacts of H.R. 2297 are negligible consisting of a one-time-only planning grant authorization of \$30 million. Thirty million dollars is how much Americans spend on health care every 25 minutes—a small price to pay for the implementation of a cost-effective, universally accessible State system.

It is my hope that we can break the national paralysis that currently afflicts our body politic when it comes to health care reform. If that can be done at the national level, such as through the enactment of Representative Russo's legislation, I urge that we move forward in the debate. But, let's not let our own paralysis become a barrier to State innovation and experimentation. Perhaps, as happened in Canada in health care reform, and has happened again and again in our own Federal system, flowers will grow and bloom at the State level that will finally convince the naysayers here in Washington. That is why I urge this subcommittee to support H.R. 2297.

Thank you Mr. Chairman. I appreciate the opportunity to testify at this important hearing today.

Mr. WAXMAN. Any questions of him? I understand you do have to leave. Thank you.

We will hear from Mr. Russo.

STATEMENT OF HON. MARTY RUSSO

Mr. Russo. Mr. Chairman, thank you very much for giving me this opportunity to testify before your committee.

Everyone agrees: Our health care system needs reform. A universal, single-payer health care system is the obvious answer to our Nation's health care dilemma. And I'm not the only one that has such faith in a universal, single-payer system. Both the General Accounting Office and the Congressional Budget Office have testified that single payer is the only system that can guarantee universal, comprehensive health care to all Americans and do so for less than we spend right now on health care.

A single-payer system saves because it gets rid of the enormous waste in our increasingly complicated system. My constituents

complain constantly about skyrocketing health insurance premiums and mountains of incomprehensible paperwork generated by our inefficient system. This kind of waste resulted in administrative expenditures of between \$125 billion and \$160 billion last year. This means up to 24 cents of every dollar spent for health care was wasted on administrative and billing costs.

The GAO reports that shifting to a single-payer system would save the United States \$67 billion in administrative costs alone. Insurance overhead would be cut by \$34 billion, while hospital and physician administrative costs would be reduced by \$33 billion.

Furthermore, the GAO anticipates substantial savings through global budgeting, fee schedules and controls on expensive technology. These savings would not only finance high-quality health care for the uninsured, but would eliminate the heavy burden of copayments and deductibles on hard working middle income Americans.

The legislation I have introduced would implement the key features supported by GAO in its report. H.R. 1300, the Universal Health Care Act of 1991, would establish a universal, single-payer health program which would cut the Nation's health care costs while guaranteeing comprehensive, high-quality health care for all Americans.

Let me make this clear, Mr. Chairman. My proposal is not the Canadian system. It is an American system. It is about the things we, as Americans, hold dear and have come to expect—freedom of choice, quality care and the efficient and fair use of our hard earned dollars. This bill is about containing costs because Americans can't afford to pay \$4,500 for every man, woman and child by the end of the decade.

Above all, it is about giving Americans the peace of mind they deserve so that when their children are sick they can take them to the doctor without having to worry about paying a high deductible. Or that when they change jobs they won't lose their health insurance. Or that when their mother or father needs long-term care, they won't have to mortgage their home or postpone their kids' college education.

We can't afford to do anything less than single payer. Partial solutions like insurance reform or mandated benefits won't work because they would allow insurance companies to administer health care. Insurance companies would continue wasting billions on paperwork and would be unable to implement meaningful cost containment. This means costs would continue to skyrocket, pricing more and more Americans out of the health care system.

Americans trust and respect their doctors and nurses, but they are fed up with the wasteful way insurance companies manage our health system. Opinion polls indicate that 89 percent of Americans believe our system needs fundamental change. Not surprisingly, a recent Wall Street Journal poll found that 62 percent of voters support single payer, including 60 percent of conservatives.

I am tired of hearing everyone with an inside-the-beltway attitude say that single payer is the best system, but it could never happen in the United States. The American people want it, and they deserve it. For the amount of money we spend, Americans should be living 2 years longer than Canadians, not the other way around.

H.R. 1300 has the support of 50 members of Congress, including three distinguished members of this subcommittee, as well as 10 major unions, Citizen Action, several consumer activist groups, the National Council of Senior Citizens and the Physicians for a National Health Care Program.

My proposal offers the framework for how health reform should be structured to guarantee that America truly has the best health reform system in the world, not just the most expensive.

I look forward to working with you, Mr. Chairman, all members of your subcommittee, and welcome suggestions for improving my plan. I would be happy to answer any questions you might have.

Mr. WAXMAN. Thank you very much, Mr. Russo.

[The attachments to Mr. Russo's prepared statement follow:]

The Russo Bill Highlights

Major Provisions

- *Universal access to health care* through a single, publicly-administered program.
- *Comprehensive benefits for all Americans*, including hospital and physician care, dental services, long-term care, prescription drugs, mental health services, and preventive care.
- *No financial obstacles to care* -- no cost-sharing, no deductibles, no copayments.
- *Freedom of choice* so that everyone can choose their own physician or source of care.
- *Cost savings* through annual budgets and a national fee schedule so that health dollars are spent efficiently and effectively.
- *Progressive financing* to make health care affordable for all.
- *Quality* measures to improve the type of medical care we receive.
- *Uniform federal standards* to guarantee that all Americans receive full access to comprehensive, quality care coupled with state administration so that implementation decisions reflect local needs.

Major Benefits

- People get the health care they need, rather than the health care they can afford or their insurance company is willing to pay for.
- The nation saves \$40 billion in health care costs (and those savings grow over time) by substituting a single, publicly-administered and publicly-accountable program for the more than 1500 private insurance plans now in place. A single plan gets rid of paperwork, marketing and advertising, and other costs caused by the insurance industry.
- Senior citizens save \$33 billion -- one-third of their current health costs -- and get long-term care, prescription drug, preventive and other new benefits.
- The non-elderly save \$25 billion and won't have to worry about rising insurance premiums, cost-shifting, paying for children's health bills, or losing health coverage if they change jobs.
- Businesses that provide health care benefits to their workers lower their costs, can compete more fairly in the world market, and have more funds available to improve their operations and create jobs.
- State and local governments save \$7 billion and no longer face the devastating budget impacts of unexpected and skyrocketing health care costs.
- Physicians, nurses and other providers spend more time caring for patients instead of filling out insurance forms and justifying their medical judgments to insurance company bureaucrats.

**Health Care Spending Goals By Sector
1989, Russo Bill (\$ Billion)**

Sector	Current	Russo Bill	Change	Notes
Business	\$176	\$199	+\$23	
Employee Health Insurance	\$129	\$0	-\$129	Eliminated
HI Payroll Taxes (Employer Share)	\$31	\$169	+\$138	Increase by 6 percentage points; no wage cap
Workers Comp (Medical Costs Only)	\$14	\$0	-\$14	Eliminated
In-plant Health Services	\$2	\$2	\$0	Retained
Corporate Income Tax Increase	\$0	\$27	+\$27	Top rate up from 34% to 38% for businesses with more than \$75,000 profits; \$15 billion in reforms
Non-Elderly	\$135	\$111	-\$25	
Out of Pocket Payments	\$71	\$28	-\$43	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
HI Taxes (Employee Share)	\$37	\$38	+\$1	Current 1.4% tax retained; extended to all workers
Private Insurance for Covered Services	\$28	\$0	-\$28	Eliminated
Personal Income Tax Increase	\$0	\$45	+\$45	New 15%-30%-34%-38% rates; \$8 billion in reform
Elderly	\$84	\$51	-\$33	
Out of Pocket Payments	\$54	\$15	-\$39	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
Private Insurance for Covered Services	\$18	\$0	-\$18	Eliminated
Medicare Part B Premiums	\$11	\$18	+\$6	New long term care/health premium equal to Part B premium plus \$25/month for those above 120% of poverty
Added Tax on Benefits	\$0	\$6	+\$6	Part of Social Security benefits included as taxable income; includes low income protection
Personal Income Tax Increase	\$0	\$12	+\$12	New 15%-30%-34%-38% rates; \$6 billion in reforms
State and Local Government	\$83	\$76	-\$7	
Medicaid & Other Public Programs	\$62	\$54	-\$8	Maintain 85% of Medicaid effort; \$85 per capita fee; maintenance of noncovered services
Employee Health Insurance	\$17	\$0	-\$17	Eliminated
HI Taxes (Employer Share)	\$4	\$22	+\$18	All workers covered; rate up 6 pct. points; no wage cap
Other Private (Charity etc)	\$16	\$16	\$0	
Federal Government	\$96	\$96	\$0	
Health Programs (Net)	\$88	\$96	+\$8	Maintain current effort, including employee health costs
Employee Health Insurance	\$8	\$0	-\$8	Eliminated
Total Health Spending	\$589	\$549	-\$40	

The Russo Bill
Impact on Businesses that Now Provide Health Insurance

Major Provisions

- Replaces current employment/private insurance system with publicly-administered program.
- Replaces current business costs of providing employee health care -- including health insurance premiums for current workers and retirees, self-insurance costs, and workers compensation -- with a 7.5 percent payroll tax and an increase of 4 percentage points in the corporate income tax rate on the most profitable firms.

Major Benefits

- Eliminates competitive disadvantages -- domestic and international -- faced by companies providing health coverage for their employees.
- Allows businesses to hire whomever they want -- without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs
- By controlling runaway medical inflation, eliminating waste and requiring that all businesses contribute their fair share, businesses now providing health benefits will save money, allowing them to improve their operations and expand job opportunities. (Currently, over 90% of after-tax profits are spent on health benefits, up from 74% in 1984 and 14% in 1965).

**Average Health Benefit Costs and Savings as a Percent of Payroll
for Companies Currently Providing Health Benefits, 1989**

Industry	1989 Payroll Costs	Payroll Cost Savings	Industry	1989 Payroll Costs	Payroll Cost Savings
Total All Industries	11.6	4.1	Machinery	7.4	-0.1
Total, All Manufacturing	12.1	4.6	Elect. Mach., Equip & Supplies	11.2	3.7
Food, Beverages and Tobacco	9.3	1.8	Transportation Equipment	13.7	6.2
Textile Products and Apparel	9.4	1.9	Instruments and Misc	11.0	3.5
Pulp, Paper, Lumber, & Furn.	10.4	2.9	Total all Non-manufacturing	11.3	3.8
Printing and Publishing	8.0	0.5	Public Utilities	13.7	6.2
Chemicals and Allied Products	14.8	7.3	Department Stores	7.0	-0.5
Petroleum Industry	10.3	2.8	Trade (Wholes. & other Retail)	12.9	5.4
Rubber, Leather and Plastic	15.7	8.2	Banks, Finance, etc	7.7	0.2
Stone, Glass and Clay Products	10.6	3.1	Insurance	10.0	2.5
Primary Metal Industry	14.4	6.9	Hospitals	10.1	2.6
Fabricated Metal Products	19.3	11.8	Misc Nonmfg Industry	10.0	2.5

NOTE: Calculations based on 1989 survey of approximately 1,000 companies by U.S. Chamber Research Center, Employee Benefits, 1990 Edition. Includes employer HI tax liability and medical component of workers' compensation, but not corporate income tax liability data, for which data was not available.

The Russo Bill Impact on a Family of Four

Major Provisions

- Provides families with full access to comprehensive medical care -- including preventive care, prescription drugs, and long-term care -- at the physician, hospital or provider of their choice.
- Prohibits deductibles and copayments for covered services.
- Eliminates private health insurance and out-of-pocket costs for covered services, retains the current 1.45% HI payroll tax, and increases personal income tax on top brackets

Major Benefits

- Non-elderly families and individuals save \$25 billion in insurance and out-of-pocket costs.
- All families are guaranteed full health care, including annual checkups, dental care, immunizations and prescription drugs.
- Coverage cannot be lost or reduced because of changes in employment or health status.
- Families will no longer have to rely on private insurance companies to provide affordable coverage and approve their claims or face the threat of financial disaster if someone gets sick - all costs are fully covered by the national health plan.

**Changes In Personal Income Taxes and Average Health Care Savings
for a Family of Four, 1990 Income Levels**

Income Level	Personal Income Tax Increase	Average Out-of-Pocket Health Care Savings
Lowest 20 percent (Average income = \$12,800)	\$0	\$930
Second 20 percent (Average income = \$27,400)	\$0	\$1,440
Third 20 percent (Average income = \$39,200)	\$0	\$1,590
Fourth 20 Percent (Average income = \$54,000)	\$50	\$1,750
Next 15 percent (Average income = \$81,600)	\$460	\$2,020
Next 5 percent (Average income = \$273,100)	\$12,290	\$2,620

Note: These figures are for non-elderly families of four. Current health care costs covered by plan include covered out of pocket expenses (including insurance). Tax figures assume no special break for capital gains (treated as regular income) and additional personal income tax reforms affecting high income families.

The Russo Bill Impact on Senior Citizens

Major Provisions

- Provides comprehensive coverage, including long-term care, home care, prescription drugs, and preventive services not now covered by Medicare. There are no copayments or deductibles.
- Senior citizens contribute to the National Health Trust Fund through a monthly long-term care/health premium (equal to Part B premium plus \$25/month), an increased personal income tax on those in the top income brackets, and a provision to increase the portion of Social Security benefits included as taxable income.
- Senior citizens with incomes below 120% of poverty do not pay the monthly premium and are not affected by the Social Security or personal income tax changes.

Major Benefits

- Saves senior citizens \$33 billion in current health care costs.
- Eliminates out-of-pocket costs and balance billing for covered services; gets rid of Medicare deductibles and cost-sharing.
- Protects those now facing cutbacks in coverage and/or increased cost-sharing as businesses reduce retiree benefits.
- Protects retirees from losing health care benefits if their firm goes bankrupt.
- Eliminates the need for Medigap insurance.

**Average Net Savings from Russo Bill
For Senior Citizens Not on Medicaid**

	Single Households		Married Couples	
	Median Income	Net Savings	Median Income	Net Savings
Lowest Fifth	\$5,370	\$1,120	\$11,958	\$2,161
Second Fifth	\$10,548	\$1,131	\$26,238	\$2,159
Middle Fifth	\$13,520	\$1,424	\$39,631	\$2,165
Fourth Fifth	\$22,843	\$1,717	\$55,603	\$2,518
Highest Fifth	\$62,801	\$1,086	\$133,414	\$2,878

Note: Net savings are based on a comparison of average household spending for taxes, Medicare premiums, and out-of-pocket expenses.

Mr. WAXMAN. Now we would like to hear from Ms. Oakar.

STATEMENT OF HON. MARY ROSE OAKAR

Mr. OAKAR. Thank you very much, Mr. Chairman, and members of the committee.

Mr. Chairman, first of all, I want to congratulate you on your ceaseless efforts with respect to health care and especially thank you for including in the previous bill the women's health agenda, at least part of it, and we are very, very grateful. We hope that that authorization is sustained, and, hopefully, it will be.

Mr. Chairman, you and I served on the Pepper Commission together, and over an 18-month period we really studied things that instinctively we knew. We knew a lot of people were not insured or underinsured. I did not realize 77 million Americans are noninsured or underinsured in this country. Nobody I know of—and there are 8 million who need this type of care—nobody I know of has a decent policy respective to long-term care, that is, homemaker and nursing home care.

And so we have a crisis, and yet Americans spend more. I think it is instructive to look at what we spend—and these are old statistics. They get worse. We spend 43 percent more in per capita health costs than Canada, 87 percent more per capita than West Germany, 132 percent more on health care per capita than Japan. And yet we are the only country that is industrialized without affordable, accessible health care for every citizen—except South Africa. And I think it is a disgrace and a crisis. And in a bipartisan way, if it is possible, we ought to put it on the agenda.

So what do I propose in H.R. 8? I propose a government-based single-payer plan with a very high standard. I think we have to change the standard of coverage as well of minimum benefits which I think is restricted private sector participation. It would be a private public partnership and that is how it differs from—in some ways at least—from the Russo plan. I think we should keep the private sector plan involved.

Let me just go into the contents for a minute. I think it is very, very important to have coverage related to hospital care, surgery, in- and outpatient care, et cetera. Prevention is very important. There are very few policies that cover child vaccinations, prenatal care, pap smears, mammograms, cancer screening for men.

And I also think with respect to prevention we ought to make a wholesale effort to find a cure for diseases. Why should Americans be spending \$90 billion for Alzheimer's disease, when if we invested in research we might be able to cure that disease? Part of preventative health care ought to include, in my judgment, research as well. But most policies don't contain that.

And as we have found from figures in the Pepper Commission—we found that over a 3- to 5-year period when you add preventive benefits you save money and save lives. It is not true that you spend more money over a 3- to 5-year period when you add prevention.

What about long-term care? I honestly think that we need to provide this type of coverage, homemaker and community-based care services, for our people, including nursing home care for at least up

to 6 months, since the average person in a nursing home stay is there about 4 months.

We know very well that the good news is that people are living longer, but we have 70-year-old kids taking care of 85-year-old parents. Mr. Chairman and colleagues, they just can't do it.

We have families with children with chronic diseases. Why should they have to institutionalize that child when if we had congregate services assisting them with respect to home care and long-term care that child could stay under the loving care of their parents and family.

So having—changing the standards so that you include acute care and long-term care and prevention is what I am about. Having a single payer is what I am about.

Mr. Chairman, in conclusion let me just say this: How do you save money? You save money by having a single payer. You save money by including prevention. You save money by having global State health State budgets and having private sector, nonprofit insurance companies bid on this high standard, and by consolidating all of these various governmental programs and by not being biased in terms of who serves.

We ought to have all licensed health professionals part of the team serving our people, instead of just reimbursing the most expensive types of individuals.

And I think that ultimately we will succeed. With your help and everybody's banding together on an American problem, we will find a solution.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Ms. Oakar, for that presentation.

[The prepared statement of Ms. Oakar follows:]

STATEMENT OF THE HONORABLE MARY ROSE OAKAR
 MEMBER OF CONGRESS FROM OHIO
 before the
 HOUSE ENERGY AND COMMERCE COMMITTEE
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
 July 29, 1991

CHAIRMAN WAXMAN, I AM VERY PLEASED TO BE HERE TODAY. I THANK YOU FOR YOUR CONTINUED LEADERSHIP ON THE QUESTION OF THE FUTURE OF HEALTH CARE AND ACCESS TO HEALTH CARE IN THE UNITED STATES. THIS HEARING IS AN IMPORTANT STEP FORWARD TOWARD DEALING WITH WHAT I BELIEVE WILL BE THE MOST SERIOUS DOMESTIC ISSUE THIS CONGRESS WILL FACE IN THE 1990's. MR. CHAIRMAN, I FOUND THAT YOU WERE A STRONG ADVOCATE FOR MANY OF MY RECOMMENDATIONS WHEN WE SERVED TOGETHER ON THE PEPPER COMMISSION -- INCLUDING THE STRUCTURAL FRAMEWORK FOR REFORM I PRESENT HERE TODAY. THE AMERICAN EPOPLE ARE FORTUNATE TO HAVE SUCH A STAUNCH ADVOCATE FOR UNIVERSAL HEALTH COVERAGE LIKE YOU AT THE HELM OF THIS IMPORTANT HEALTH SUBCOMMITTEE. ESPECIALLY AT THIS CRITICAL JUNCTURE IN OUR HISTORY.

IN THE PAST YEAR, ALMOST EVERY NEW STUDY SUPPORTS WHAT MANY OF US HAVE BEEN SAYING ALL ALONG -- WE ARE ALREADY PAYING THE COST OF UNIVERASAL HEALTH CARE AND LONG-TERM CARE IN THIS COUNTRY. THE PRIVATE SECTOR HAS HAD A FAR LESS EFFICIENT TRACK RECORD. BUT THE WORST ASPECT OF OUR SYSTEM IS THE PATCHWORK OF CONFUSING AND OVERLAPPING POLICIES THAT ALLOW SUBSTANDARD CARE FOR THE POOR AND ELDERLY, AND ALLOW WORKING MIDDLE INCOME FAMILIES TO FALL COMPLETELY THROUGH THE CRACKS.

MR. CHAIRMAN, I AM CONVINCED THAT LAST YEAR'S PEPPER COMMISSION REPORT DEVELOPED A CONSENSUS ON THE NEED FOR A MOVEMENT TOWARD FOR UNIVERSAL ACCESS TO HEALTH COVERAGE AND LONG-TERM CARE, ALONG WITH MEANINGFUL COST CONTAINMENT THAT MANY THOUGHT WAS NOT POSSIBLE FROM A BI-PARTISAN COMMISSION. PERHAPS THE COMMISSION WAS NOT SO SUCCESSFUL IN ESTABLISHING A CLEAR CONSENSUS ON DETAILED STRATEGY. HOWEVER, FOLLOWING THE COMMISSION'S LANDMARK REPORT, THE PARAMETERS OF DEBATE DID MOVE FORWARD FROM WHETHER THERE IS A NEED FOR ACTION, TO WHAT TYPE OF ACTION WE MUST TAKE. THIS, I BELIEVE, IS THE LEGACY OF THE PEPPER COMMISSION. MUCH CREDIT IS DUE TO COMMISSION CHAIRMAN ROCKEFELLER FOR HIS SUCCESSFUL EFFORT TO OVERCOME INTENSE LOBBYING AGAINST ANY AGREEMENT ON THE VERY NATURE OF THE PROBLEM. AT THIS TIME LAST YEAR, THE PEPPER COMMISSION TOOK A VERY SIGNIFICANT STEP FORWARD IN ESTABLISHING THIS DEBATE.

SINCE THEN MANY PROPOSALS HAVE EMERGED WHICH ALL HAVE MERIT FOR OUR CONSIDERATION. THESE PLANS ARE NUMEROUS AND THE PROBLEM IS COMPLEX. THAT IS WHY I AM NOW CALLING UPON ALL OF MY COLLEAGUES TO JOIN ME IN THE CREATION OF A BI-PARTISAN CONGRESSIONAL CAUCUS FOR NATIONAL HEALTH CARE REFORM. AS YOU HAVE RECOGNIZED THROUGH THESE HEARINGS OF THIS DISTINGUISHED COMMITTEE, MR. CHAIRMAN, WE MUST BEGIN THE PROCESS TO DEVELOP A CLEAR CONSENSUS ON STRATEGIES FOR REFORM. SUCH A CAUCUS COULD SERVE AS A RESOURCE TO HELP MEMBERS SORT THROUGH THE CONFUSION. SO FAR, ALMOST 70 MEMBERS HAVE JOINED

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THE BI-PARTISAN CONGRESSIONAL CAUCUS FOR NATIONAL HEALTH CARE REFORM. CONGRESSMAN MATTHEW RINALDO AND MYSELF ARE CO-CHAIRING THE CAUCUS, AND REPRESENTATIVES TORRES AND HOBSON ARE OUR VICE-CHAIRS. WE HAVE SCHEDULED A SPECIAL ORDER ON HEALTH CARE REFORM FOR THE CLOSE OF BUSINESS THIS WEDNESDAY, AND I ENCOURAGE ANY MEMBER OF THIS IMPORTANT SUBCOMMITTEE TO JOIN US AND SHARE YOUR INSIGHT.

AS AN ACTIVE FORMER MEMBER OF THE PEPPER COMMISSION, LET ME BEGIN BY STATING MY CONVICTION THAT UNIVERSAL COVERAGE OF ALL AMERICANS FOR COMPREHENSIVE HEALTH CARE AND LONG TERM CARE FROM THE CRADLE TO THE GRAVE WILL BE AN ANCHOR ISSUE IN THE 1990's. ACCESS TO A HIGH MINIMUM STANDARD OF HEALTH CARE SHOULD BE A BASIC GUARANTEED RIGHT FOR AMERICAN CITIZENS. YET IN OUR NATION, WE TREAT HEALTH CARE MUCH THE SAME AS WE TREAT ANY OTHER COMMODITY. THE FACT REMAINS THAT THE UNITED STATES IS THE ONLY INDUSTRIALIZED NATION, OTHER THAN SOUTH AFRICA, THAT DOES NOT PROVIDE UNIVERSAL HEALTH CARE COVERAGE TO ALL OF ITS CITIZENS. LAST YEAR THE CENSUS BUREAU REPORTED THAT 63 MILLION AMERICANS, OR 28% OF THE POPULATION LACKED HEALTH INSURANCE FOR SUBSTANTIAL PERIODS OVER A 28 MONTH REVIEW. 37 MILLION AMERICANS HAVE ABSOLUTELY NO HEALTH INSURANCE IN OUR COUNTRY AND LONG TERM CARE COVERAGE IS AN OPTION ONLY FOR THE VERY RICH OR THE VERY POOR. EIGHT MILLION AMERICANS ARE IN NEED OF VERY EXPENSIVE LONG-TERM CARE AND THIS NUMBER WILL EXPLODE OVER THE NEXT TWO DECADES. MEANWHILE, THE UNITED STATES SPENDS MORE PER CAPITA ON HEALTH CARE THAN ANY OTHER NATION -- 43% MORE THAN CANADA, 87% MORE THAN WEST GERMANY, AND 132% MORE THAN JAPAN. WE SPEND MUCH MORE AND WE GET MUCH LESS BECAUSE WE DON'T DEAL WITH HEALTH CARE IN A COMPREHENSIVE FASHION IN OUR NATIONAL HEALTH POLICY. WE CANNOT REMAIN COMPETITIVE AS A NATION WHEN WE SUBSIDIZE THE HEALTH CARE OF OTHER NATIONS AT THE EXPENSE OF OUR OWN PEOPLE.

UNDERLYING MY PHILOSOPHY ON HEALTH POLICY ARE TWO VERY BASIC BELIEFS. THE FIRST IS THAT COVERAGE SHOULD BE UNIVERSAL AND THE SECOND IS THAT THIS COVERAGE SHOULD PROVIDE A HIGH MINIMUM STANDARD. I AM CONVINCED THAT WE CAN ACCOMPLISH THIS FOR THE SAME AMOUNT OF MONEY OUR NATION, AS A WHOLE, CURRENTLY SPENDS ON HEALTH CARE. THROUGH THE ADOPTION OF A SINGLE-PAYER SYSTEM, INCREASED EMPHASIS ON PREVENTIVE CARE, THE ELIMINATION OF UNCOMPENSATED CARE, THE REGULATION OF THE DISTRIBUTION OF CAPITAL COSTS AND AN INCREASED COMMITMENT TO BIO-MEDICAL RESEARCH WE CAN INCREASE THE QUALITY OF LIFE FOR OUR PEOPLE AND BEGIN TO CONTAIN DOUBLE DIGIT HEALTH CARE INFLATION. OUR NATION'S COMMITMENT TO MEDICAL RESEARCH HAS, IN MANY WAYS BEEN BENEFICIAL TO ENSURING CONSUMER ACCESS TO THE BEST IN AVAILABLE MEDICAL TECHNOLOGY. IT IS THE CONGRESS AND THE ADMINISTRATION THAT SET HEALTH POLICY IN OUR NATION. WE CONTINUE TO SEEK PIECEMEAL SOLUTIONS TO CONTROLLING THE SPIRALLING HEALTH CARE COSTS IN OUR COUNTRY, RATHER THAN CHOOSING TO GRAB THE BULL BY THE HORNS AND ADOPT A NATIONAL APPROACH. THERE HAVE BEEN GROSS ABUSES AND INCREDIBLE WASTE IN OUR PRIVATE SYSTEM

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DUE TO THE LACK OF GUIDELINES THAT WE SET FOR GUARANTEEING THE ADEQUACY OF HEALTH DELIVERY AND HEALTH ACCESS FOR OUR PEOPLE. THE PRIVATE INSURANCE INDUSTRY MUST BE MORE STRICTLY REGULATED IN OUR NATION. MR. CHAIRMAN, I BELIEVE THE PEPPER COMMISSION RECOMMENDATIONS, WHICH YOU AND I SUPPORTED, MOVE US IN THAT DIRECTION. YET, FOR VERY PRAGMATIC REASONS, I PREFER THAT CONGRESS ADOPT LEGISLATION SIMILAR TO H.R. 8, THE UNIVERSAL HEALTH CARE FOR ALL AMERICANS ACT.

FOR THE MOST PART, IT IS NOT THE INDIGENT WHO ARE UNINSURED IN OUR COUNTRY. MOST OF THE UNINSURED COME FROM MIDDLE-INCOME, WORKING FAMILIES. I THINK IT IS TERRIBLE THAT HEALTH INSURERS IN OUR NATION SHUT OFF THOSE WHO HAVE A PRE-EXISTING CONDITION. WHEN THE PEPPER COMMISSION HELD HEARINGS IN MY DISTRICT, ONE OF THE WITNESSES WAS A SELF-EMPLOYED ENTREPRENEUR WITH AN ANNUAL INCOME OF \$70,000. BECAUSE OF A PRE-EXISTING CONDITION SHE COULD NOT BUY HEALTH INSURANCE FOR ANY PRICE. WHEN SHE DEVELOPED HER CONDITION SHE LOST HER COVERAGE ALTHOUGH SHE DUTIFULLY PAID HER PREMIUMS FOR YEARS. I KNOW THAT THIS PARTICULAR CASE MIRRORS WHAT IS HAPPENING ALL ACROSS OUR COUNTRY. IN CONTRAST, H.R. 8 WOULD GUARANTEE HEALTH COVERAGE REGARDLESS OF PRE-EXISTING CONDITIONS. WE HEARD FROM THOSE WHO PERPETUATE THE MYTHS ABOUT HEALTH CARE RATIONING IN OTHER NATIONS. HOWEVER, THE HEALTH CARE RATIONING THAT IS WIDESPREAD IN THE UNITED STATES IS THE MOST ONEROUS OF ALL, AS IT IS BASED ON ABILITY TO PAY OR APPLIED AGAINST THOSE IN GREATEST NEED.

ANOTHER ABUSE OF OUR SYSTEM IS THE LACK OF PREVENTIVE COVERAGE AVAILABLE IN MOST HEALTH PLANS. WE NEED A COMPLETE REVERSAL IN PHILOSOPHY HERE AND NOT JUST THE ADDITION OF ASSORTED PREVENTIVE BENEFITS, ALTHOUGH THESE ARE A CRUCIAL COMPONENT. WE MUST DISPENSE WITH THE RIDICULOUS NOTION THAT HEALTH COSTS CAN BE CONTAINED THROUGH MANAGED CARE CONSULTANTS' REFUSAL TO COVER ANYTHING BUT THAT WHICH IS DEEMED "MEDICALLY NECESSARY." WE ARE PUSHING PATIENTS OUT OF CARE QUICKER AND SICKER ONLY TO PAY MORE DOWN THE ROAD FOR INEVITABLE, PREVENTABLE COMPLICATIONS. WE MUST FOSTER THE NOTION THAT AMERICANS SHOULD BECOME PARTNERS WITH THEIR PROVIDERS IN THEIR OWN HEALTH MAINTENANCE. IT TOOK YEARS OF INTENSIVE LOBBYING ON MANY FRONTS TO GET THE TWENTY-NINE STATES ON BOARD WHO NOW REQUIRE PRIVATE INSURERS TO COVER REGULAR MAMMOGRAPHY SCREENING. REFUSAL TO COVER PREVENTIVE SERVICES SUCH AS IMMUNIZATIONS, PAP SMEARS, OR SIMPLE ROUTINE CHECK-UPS MAKES NO SENSE FROM A HEALTH CARE STANDPOINT OR FROM A BUSINESS STANDPOINT. EARLY DETECTION OF MAMMOGRAPHY SCREENING IS PROVEN TO REDUCE BREAST CANCER MORTALITY BY AS MUCH AS THIRTY PERCENT. EARLY TREATMENT OF BREAST CANCER COSTS, ON AVERAGE, \$15,000 WHILE TREATMENT IN LATER STAGES MAY COST 65,000 OR MORE. THE PEPPER COMMISSION PROPOSAL, SIMILAR TO MY BILL, PLACES A HEAVY EMPHASIS ON PREVENTIVE SERVICES AS BOTH HUMANE AND COST-EFFECTIVE.

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ALSO, MOST PRIVATE HEALTH INSURANCE PLANS AVAILABLE ON THE MARKET TODAY DO NOT ADEQUATELY COVER HOME HEALTH, HOSPICE, AND RESPIRE SERVICES. THESE ARE OFTEN THE MOST SENSIBLE, HUMANE ALTERNATIVES TO MORE EXPENSIVE, IMPERSONAL INSTITUTIONALIZATION FOR THOSE WHO DO NOT NECESSARILY NEED SUCH CARE. BY THE SAME TOKEN, MANY STATES CURRENTLY DO NOT REQUIRE PRIVATE PLANS TO DIRECTLY REIMBURSE LICENSED HEALTH PROFESSIONALS SUCH AS NURSE PRACTITIONERS AND NURSE MIDWIVES FOR THEIR SERVICES.

MR. CHAIRMAN, THE FACT REMAINS THAT THE PROBLEMS OF ACCESS TO CARE, ADEQUACY OF CARE, AND THE RISING COST OF CARE ARE ALL LINKED TO ONE ANOTHER. WE CANNOT ADEQUATELY ADDRESS ANY OF THESE PROBLEMS UNLESS WE ADDRESS THEM ALL AT ONCE, COMPREHENSIVELY. ONE OF THE PROBLEMS THAT DRIVES UP HEALTH COSTS IN OUR COUNTRY IS THE CONFUSION OF PAPERWORK THAT COMES WITH DIVERSE STATE REGULATORY STRUCTURES AND A CONFUSING MULTITUDE OF BENEFIT SYSTEMS. THE PEPPER COMMISSION RECOMMENDATIONS DO NOT ADDRESS THIS ISSUE. MY LEGISLATION H.R. 8 DOES SET UP A SINGLE PAYER SYSTEM. THE PEPPER COMMISSION STAFF ESTIMATED THAT SUCH A SYSTEM COULD SAVE AT LEAST \$30 BILLION PER YEAR IN REDUCED OVERHEAD COSTS ALONE. THE GAO REPORT RECENTLY RELEASED INDICATES THAT FIGURE IS EVEN HIGHER.

THE STRUCTURAL CENTERPIECE OF H.R. 8, THE UNIVERSAL HEALTH CARE FOR ALL AMERICANS ACT IS A STATE-FEDERAL PARTNERSHIP WHICH GUARANTEES A HIGH MINIMUM STANDARD OF HEALTH COVERAGE TO ALL CITIZENS. THE BILL WOULD CREATE A UNIQUELY AMERICAN HEALTH SYSTEM AND CENTERS ON STATE DELIVERY OF SERVICES WITH FEDERAL OVERSIGHT AND CONTRIBUTIONS. STATES WOULD ACCEPT BIDS TO PROVIDE, AT LEAST, THE MINIMUM BENEFITS DESCRIBED IN THE BILL, AND WILL BE FREE TO SELECT AS MANY PLANS AS THEY WISH TO ADMINISTER. ANY GROUP, INCLUDING PRIVATE INSURERS, HOSPITALS, HMOs, PPOs, ETC. WOULD BE ENCOURAGED TO BID FOR STATES' ACCEPTANCE. IN ADDITION TO THE CURRENT STATE AND FEDERAL GOVERNMENT EXPENDITURES ON HEALTH CARE, THE \$200 BILLION IN PREMIUMS CURRENTLY PAID BY INDIVIDUALS AND CORPORATIONS DIRECTLY TO THESE PROVIDERS WOULD HAVE TO BE RECAPTURED BY THE STATE AND FEDERAL GOVERNMENTS TO PAY FOR THE PLAN.

MR. CHAIRMAN, AGAIN, AS A NATION, THE \$670 BILLION WE ALREADY PAY FOR A GROSSLY INADEQUATE HEALTH CARE SYSTEM, WOULD JUST AS WELL PAY FOR A PLAN SUCH AS MINE. THE TOTAL NEW GOVERNMENT COST OF THE PLAN HAS BEEN ESTIMATED BY THE PEPPER COMMISSION STAFF AT \$234 BILLION -- AN EQUIVALENT AMOUNT IN DIRECT OUT-OF-POCKET PAYMENTS BY INDIVIDUALS AND EMPLOYERS TO PRIVATE INSURERS WOULD BE ELIMINATED. THAT IS, AS I MENTIONED, NOT MUCH MORE THAN AMERICANS CURRENTLY SPEND ON INADEQUATE PRIVATE INSURANCE WHICH, FOR THE MOST PART, DOES NOT COVER LONG-TERM CARE.

MR. CHAIRMAN, A RECENT SURVEY INDICATES THAT 67% OF AMERICANS WOULD FAVOR A PLAN SIMILAR TO CANADA'S WHICH GUARANTEES UNIVERSAL HEALTH COVERAGE AND LONG-TERM CARE. A GROWING NUMBER OF AMERICANS WOULD PREFER TO PAY A REGULAR PREMIUM TO THE GOVERNMENT IN RETURN FOR A GUARANTEED STANDARD OF HEALTH AND LONG-TERM CARE COVERAGE. I DO NOT BELIEVE THAT THE CONGRESS WILL BE ABLE TO IGNORE THIS GROWING MANDATE MUCH LONGER. I WILL CONTINUE TO FIGHT FOR SUCH A PLAN. THANK YOU AGAIN, MR. CHAIRMAN, FOR FORGING AHEAD ON THIS ISSUE. I THANK ALL THE MEMBERS OF THE COMMITTEE FOR HEARING MY TESTIMONY AND I LOOK FORWARD TO OUR CONTINUED WORK TOGETHER.

Mr. WAXMAN. Mr. Sanders.

STATEMENT OF HON. BERNIE SANDERS

Mr. SANDERS. Thank you, Mr. Chairman, and thank you for conducting a hearing on what I suspect is the most serious problem facing the people of the United States.

I think in my own State of Vermont we have held a number of public hearings in small towns on the health care crisis, and we have been amazed by the number of people who have come out and have said the present system is no longer working, we need a major overhaul, no more tinkering, we finally must go to a national health care system which guarantees health care to every man, woman and child.

I am sure that you are familiar with the enormity of the problem. The system is disintegrating. Thirty-five million Americans today have no health insurance. What happens to those people when illness or accident strikes?

Fifty million people are underinsured, can go bankrupt as a result of a major illness. We rank 22nd in the world in terms of infant mortality. We rank 12th in the world in terms of life expectancy. Is that being number one in the world? I think not.

After all is said and done for a system which is disintegrating, we end up spending far, far more than any other nation on Earth. The Canadians who are in second place are spending 30 percent less than we are. Clearly, to my mind, the system cannot be tinkered with. We need a major overhaul. We need to do what virtually every other nation on Earth has done and move toward a national health care system.

The proposal that we are bringing forth is, in fact, a Canadian-style system, administratively and politically, as I believe Congressman Russo and Congressman Markey indicated. Canada did not move to national health care full blown in all of their provinces. It started in Saskatchewan.

My own view is that Federal and legal authority—Federal aid, increased Federal money and legal authority for those States in the country which are prepared to move forward now with a single-payer system, which is comprehensive, covers all health care needs, universal, covers every man, woman and child in the State, is portable, allows that insurance to go when people go out of their own State.

If the State is prepared to do that, they will receive a block grant which brings together Medicare, Medicaid and additional funding.

As others have indicated, it seems to me to be senseless to move forward without eliminating the private health insurance companies right now who are costing this country, according to the GAO, \$67 billion in administrative and bureaucratic waste. We no longer can afford all of the billing excess, all of the bureaucracy, all of the legal fees that presently exist.

Physicians for National Health Care estimate that the savings would be \$100 billion, and they are using more contemporary figures. The fact of the matter is we can provide health care for every man, woman and child without spending one penny more than the \$750 billion we are presently spending if we take the money out of

paperwork, out of bureaucracy, and we use that to provide health care for our people.

Now this issue of health care, to my mind, Mr. Chairman, is not simply a health-related issue. This is an issue of the political credibility of the U.S. Congress. It is not an accident that in the last election 65 percent of the American people did not bother to vote for Congress. The question that people are asking is, given the enormous problem facing the people of the country in health care and in other areas, is this Congress capable of standing up to the insurance companies, to the drug companies, to the medical specialists, to the medical equipment suppliers, the people who are making billions and billions of dollars off of a system that is disintegrating before our eyes.

The beauty of the system we are proposing is that administratively it allows the States to move forward—and I believe as someone who was a mayor for 8 years I would rather see the single-payer system rest in the hands of the State legislature of the people of the State rather than the Federal Government which is precisely what goes on in Canada also. Rather than raising all the money at the Federal level we give discretion to State governments. California may want to raise their share of the revenue different than the State of Vermont. We think that is appropriate.

Essentially what our plan does is provide additional financial health for those States who want to go forward in single-payer comprehensive universal care. We believe those States should have discretion in raising their share the best way they can do it. We think politically that is a sensible approach for this body.

Quite frankly, I am not quite sure tomorrow the U.S. Congress is prepared to move forward in terms of a shifting of the tax burden to the tune of many, many hundreds of billions of dollars. We think administratively and politically single payer administered by the States is the proper way to go. We think it is politically feasible. We look forward to your support.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Sanders.

[The prepared statement of Mr. Sanders follows:]

PREPARED STATEMENT OF HON. BERNARD SANDERS

The health care crisis has emerged as the foremost domestic issue facing the nation. Thirty five million Americans have no insurance while 50 million are uninsured. Health care costs are racing out of control, consuming an ever increasing share of our gross national product, undermining the competitiveness of our industrial base, and bankrupting both workers and employers with skyrocketing increases in health insurance premiums.

Poll after poll shows that the American people are ready for sweeping changes in our health care system. A recent poll found that 69% of Americans favor a Canadian-style health insurance system. Does Congress have the will to take up the challenge; to develop a rational, cost-effective, national health care system which will guarantee health care to all Americans?

I have introduced legislation, HR 2530, which provides the Congress an opportunity to respond in a bold and workable way. It is both a solution to the problem and politically feasible.

It is built on two key ingredients: a Canadian-style, single payer universal health care system and a state-by-state approach to implementation and administration.

A Canadian style plan is the only approach that can really

solve the basic problems afflicting American health care: spiraling costs, lack of access, and a highly regressive funding system.

A state-by-state approach allows the States to move forward now, when the crisis is acute, without a commitment to hundreds of billions in new Federal taxes.

A Canadian-style system is vital to contain costs because it would eliminate the bureaucratic waste associated with the billing, claims procedure, and paperwork of the 1,500 insurers in our multiple payer system. The GAO estimates that in the short term we can save nearly \$70 billion, sufficient resources to provide universal, comprehensive physician and hospitalization care with no co-payments and no deductibles.

The Achilles heel of the multi-payer or employer mandate approaches is that they cannot tap into these savings; in fact they would add another bureaucratic layer to a patchwork system.

The major obstacle to progress is frankly the political impasse in Congress. Virtually every one agrees change is needed. Yet we hear many excuses for failure to act. Some claim that the public will not accept a grand plan imposed from Washington. Others argue that only an incremental approach is do-able. Others argue that the problems go beyond tinkering with the present patchwork, and that we cannot afford as a nation to delay reforms

which mean real savings and cost containment.

This is precisely why my bill follows the Canadian experience in implementation as well as functioning. Just as Canada went province by province in the 1960s, so I propose that Congress allow the country to adopt a national health care policy state-by-state.

My approach empowers the states to serve as the laboratories in solving the crisis. A recent survey by Citizen Action shows that there are at least 20 states ready to embark on statewide healthcare reform. For example the Maine legislature recently enacted a measure to design a single payer state system -- and overrode a gubernatorial veto of it. This is an example how urgently the people want to move forward.

I am convinced that state demonstration programs will show that universal coverage for physician, hospital, and long term care can be achieved without spending any more on health care than we are spending right now. And since we are spending 40% more per person than the Canadians, we can avoid the waiting lists for certain high tech procedures that some Canadians must contend with.

America wants and needs to move toward a national health care system. It needs to begin now. Many states are ready to take action. The solution is for Congress to make that possible.

Mr. WAXMAN. I am pleased Congressman Gibbons is with us. We are delighted to have you here to make a presentation to us. We would like to ask, if you would, to limit oral presentation to no more than 5 minutes.

STATEMENT OF HON. SAM GIBBONS

Mr. GIBBONS. Thank you, Mr. Chairman. I think you ought to know historically how we got to where we are today and what I think is a solution to the problem.

Fifty years ago today I went off to war as a soldier in the U.S. Army. There was no health care insurance in the United States. Oh, maybe a couple of union contracts had something like that, but there was relatively nothing.

During World War II, in order to keep down inflation, wage and price controls were imposed upon the workers and businesses of this country. But in imposing those controls they left one door open and that was fringe benefits. And so, during World War II, a system of fringe benefits was developed in order to replace the dollars that the workers weren't getting because of inflation. They built up this private health care insurance system that we now have. It is an historic accident. We have let it go on, and it has brought disaster to our whole health care system.

We have not only the most expensive health care system, we have the most clumsily administered system to work with.

But we do have one system that works in this country and one system for which we already have the laws in place. We already have the administrators and bureaucracy in place. We have all the regulations written, and the people who use it like it. That is Medicare.

My proposal to this Congress is that we extend Medicare to all people, regardless of age, regardless of their status in life.

Some of the characteristics that any health care program for the United States ought to have are, first of all, that it be transportable. It should not be job dependent as our current system is. It should be open to all, regardless of their current health status or their future health status. And it should be paid for by all. It should be an insurance program just like Medicare is now.

Now why use Medicare? Medicare has 35 million participants already. It has been in existence for 26 years. It works. The hospitals know how to use it. The doctors know how to use it. The beneficiaries know how to use it. All the health care suppliers know how to use it. And, certainly, on par with all of that is that we know how to control costs under Medicare.

Unfortunately, under Medicare we get the most ill people of our population. Therefore, the medical care costs are higher than they would be for the entire working population.

If Medicare is extended to all people as I propose, then the cost of medical care would be far less in the United States than under the current system, and everybody would be assured that whenever they got sick or if they needed preventive health care or advisor counseling they could go to a doctor or to their provider and get that kind of health care.

It is not a radical program. It is not a new program. There would still be some area in there for the private insurance industry if they wanted to sell Medigap insurance to take care of those optional procedures that some people desire, for example, a private room or something of that sort over a semiprivate room that we now offer in Medicare. There are all these kinds of options that make it attractive to Americans.

It is an American program. It is a proven program. It is one that will save money to the average consumer and taxpayer. It is one that will promote better health for all Americans.

Unfortunately, most of the Americans who are now not covered by health insurance are children who really can do nothing about it, and most of them are in families where the father and the mother are both working or at least one of them is working in a job outside of their home. So we have a very vulnerable group of people in America who are not covered.

It is estimated in a year's time, Mr. Chairman, that about 60 million people are not covered by any kind of health care insurance in the United States. Not just 35 million that we see in those snapshots of one time during the year. We have a terrible need in this country. We can solve it by extending Medicare to all. We should do it at once.

Mr. WAXMAN. Thank you very much, Mr. Gibbons.

Mr. Gibbons and Mr. Russo, your programs are federally run, and, Ms. Oakar and Mr. Sanders, your programs, as I understand it, are Federal dollars to go to the States. Ms. Oakar, as I understand your proposal, you would cover not only acute care cost but long-term costs as would Mr. Russo. But Mr. Sanders and Mr. Gibbons do not cover the long term.

Mr. SANDERS. That is not correct. Our plan is a comprehensive plan covering all health care needs.

Mr. WAXMAN. It would cover nursing homes?

Mr. SANDERS. Yes. Just as the Canadian system does.

Mr. WAXMAN. You propose to send to the States a certain amount of money that would be the equivalent of what?

Mr. SANDERS. Medicaid, Medicare, plus if all 50 States entered tomorrow, which is highly unlikely, there would be a \$45 billion increase in Federal help for health care for the States. What our proposal does is eliminate the private insurance premiums that we pay out-of-pocket costs, give the States the savings a single-payer system would entail.

In my small State of Vermont, we estimate that to be \$200 million.

Mr. WAXMAN. Does your bill propose to have the Federal Government capture the amount of money that would have been spent through the private insurance market through employers, employees and after the Federal Government captures that money to send it to the States?

Mr. SANDERS. Our proposal allows the States the savings that would be entitled in a single-payer system. The States would capture that.

Mr. WAXMAN. I am not talking about the savings. The savings—the argument would go you spend less money if you have a single payer.

Mr. SANDERS. Right.

Mr. WAXMAN. Most dollars spent in the health care area are dollars that are spent without the government being involved right now. Those are employers—cover their employees.

Mr. SANDERS. Private insurance and so forth.

Mr. WAXMAN. You are going to have this replaced by a government-run-at-the-State-level health insurance.

The money that was funded, would that be raised by the Federal Government?

Mr. SANDERS. The people in the State would no longer have to pay all of this private insurance. The State would pick up the tab for that in a way they felt was best for each individual State.

Mr. WAXMAN. I see. So the States would then seek to raise the funds knowing that businesses in that State are not spending the money they had spent before?

Mr. SANDERS. That is right. We would give discretion—obviously, we expect and would believe—in my State of Vermont, we would raise it as progressively as we could. It would mean IBM would not pay private insurance. They would have to pay a higher corporate tax.

Mr. WAXMAN. What protection do you have against the idea that States would be pitted against each other, that if they move to another State in—

Mr. SANDERS. We think it might be the other way about. It makes good sense for business—if they know they don't have to pay 20 or 30 percent more every year for private insurance. So, in fact, as you know, one of the concerns that business in the United States today has in terms of its competitiveness abroad is they are competing against the countries which have national health care. We think the approach of national health care is very sensible for business, and those States to go forward will gain from that.

Mr. WAXMAN. Cost containment would be different from State to State?

Mr. SANDERS. No. What we are doing is while in giving discretion to States in terms of how you would raise your revenue in the same sense that Canada does. Some go for income tax, sales tax and so forth and so on. My preference is progressive tax. What we do say is that if a State comes into the program, it must be single payer, comprehensive, universal, portable, accessible to all. We don't grant discretion on that.

We are not saying to one State, hey, you can do it any way you want and another State you can do it any way you want. We are giving discretion on how you raise the funds, certain administrative issues, but basically it is comprehensive and universal.

Mr. WAXMAN. Mr. Russo, you did cover long term care in your proposal, so you would have the Federal Government take over the acute care insurance for everyone in this country and long term care for the elderly and disabled.

Is that correct?

Mr. Russo. That is correct. It is a comprehensive program universal, and it is publicly administered at the Federal level. I think what is important is that we get the savings of a single payer. Without a single payer, we are not able to save \$80 to \$100 billion of administrative waste that is going on today. If we save the \$80 to

\$100 billion, then we can plow it back into the system to give the kind of comprehensive, universal coverage that myself and Mary Rose and Bernie are talking about.

I think single payer is the only way to give comprehensive health care to everybody. And the beauty of it all, Mr. Chairman, is that once it is fully implemented, a single payer system saves money. It is the only plan that saves money. So you can do everything that I am talking about doing for less than the \$750 billion that we are spending today.

Mr. WAXMAN. I assume looking at your plan there would be no need for private insurance at all, but under Mr. Gibbons proposal, there would probably be a Medigap insurance market to fill in.

Mr. Russo. Well, I don't know what they would offer. I mean there wouldn't be any gap really other than private rooms that aren't medically necessary, cosmetic surgery and over-the-counter drug. If you wanted to buy a policy for that, you could.

Mr. WAXMAN. You would not prohibit private insurance?

Mr. Russo. I would not, but I will be very frank, Mr. Chairman. I don't know what they could sell.

Mr. WAXMAN. Ms. Oakar, how is your proposal different from Mr. Sanders, if you know?

Ms. OAKAR. Mr. Chairman, my proposal would be a single payer proposal that with Federal oversight and administration, but in terms of the single payer funneling down to the States. It would also have oversight over global State health budgets, but the difference is that I honestly believe if competition is good, and if you had nonprofit insurance companies, which in my city of Cleveland there are none. They are all for-profit these days. When I was growing up, most of them were not-for-profit.

But if you had them bid on this very, very high standard that had Federal oversight and single payer, then I as an Ohioan, for example, or you as a Californian would be able to choose from as Federal employees do today, providing they covered a minimum benefit of coverage, from two or three or perhaps even more kinds of policies, providing they fit the guidelines that the Federal oversight and single payer would have.

I wanted to comment just really quickly on a question you asked Mr. Sanders about who pays and so on. As you know, very instructive, and I would submit this for the record, I am sure your staff has this. But when you look at it—let's say the cost of health care in this country is \$700 billion. I have heard \$650, \$750. Let's say it is \$700 billion for the sake of discussion. It is very interesting to me that the private share, that is the share that is not public, that is not Federal, that is not State or local, is 57 percent, while the public share is about 43 percent, and that has—the public share, since 1965, has gone from 24 percent of the pie of health cost to 43 percent, and that says that the Federal Government already does serve people.

We already do give veterans benefits and CHAMPUS and Medicare and Medicaid, et cetera, et cetera. And the other point that I think is very, very important is that you ultimately do save money when you have a global State budget and an oversight for that.

You save a lot of money, billions as Mr. Russo and others have mentioned when you have a single payer, and when you consoli-

date. We are approaching this, Mr. Chairman, and my colleagues, in a piecemeal manner, and it is time to offer a comprehensive health package to people, and in long term care, I would include all ages. I don't think that is just an elderly problem. I think it is a problem for small children and their families as well who have chronic diseases.

So I really believe that you could get the health care costs down, if the public part of health care is already in place, and in that more and more we are paying for health care in this country through the public sector, not the private sector.

And finally, as you know, when we looked at that pie in the Pepper Commission, as I recall, of the \$700 billion or so dollars, about \$210 billion was private insurance. A good portion was out of pocket expenses, and the rest pretty much was public, the public pie that we already have on our Federal and State and local government.

Thank you, Mr. Chairman.

Mr. WAXMAN. Let me thank all of you for your presentation.

Mr. RUSSO. One last comment, Mr. Chairman, because I think this question of cost and how we are going to pay for the system is something that needs to be addressed. I think under the single payer system and the replacement costs for health care premiums versus taxes is the most progressive way of doing it.

But let me just deal with this whole idea we don't have enough money to do health care. There is no greater emergency facing the American public today than health care and wherever we have an emergency, the President has the authority to put it off budget and do it. For example, the S&L's. That is a great emergency. We are going to spend anywhere between \$150 to \$250 billion in addition to what we are spending today to save the thrift industry. That is off budget. We are paying for it.

How are we doing to pay for it? In interest costs in the national debt, but we are paying for it. It is a need that we said we have to deal with. Desert Storm was important for a lot of people to save the Kuwaitis, a great democratic government over there that is suppressing its people and killing its people and kicking them out. We did it for all whatever good reasons we did it for. We are spending about \$65 to \$68 billion on that.

And on Star Wars, the so-called brilliant pebbles. The brilliant pebbles in this country are young people who need better health care. We ought to be spending money on them. They are the 1000 points of light that we ought to give some battery juice to so they can start lighting up the skies for us.

Instead we say that is not an emergency so therefore, you, the Congress, have got to figure out a way of paying for it. A lot of ways to pay for it. The most important is to understand that there is an emergency and we ought to ban together, both Democrats and Republicans alike and solve this emergency, just as we are solving the S&L, just as we solved the problem with Desert Storm, just as we solved the problem with the HUD scandals, we have the obligation to the American people to solve this problem, not wait 5 or 6 or 7 years down the line, we have to solve it together. Don't worry about the cost, there are dollars there to do it, and whenever we run short, Mr. Chairman, just declare it an emergency.

Mr. SANDERS. Mr. Chairman, if I could have a last, last word.

Mr. WAXMAN. Very, very last word.

Mr. SANDERS. I don't think there is a whole lot of debate any-more that single payer is what is cost effective, is what is sensible and is what is the fair thing to do, and I really think that the issue is do we as a Congress, as a government, have the courage to take on some very politically powerful people in the insurance industry, in the pharmaceutical industry, in the AMA, what tremendous power.

We know that.

Mr. WAXMAN. Do you object if it is done at a Federal level?

Mr. SANDERS. I agree with 85 percent of what Mr. Russo is saying. The critique is right, and believe me, if we move in that direction, I would be a very happy guy. I would further move at the Statewide level.

But in either case, we are taking on the same political opponents who are very, very powerful.

Mr. WAXMAN. Let me just have the last word.

Mr. SANDERS. Your committee, you have it.

Mr. WAXMAN. I think we all want the same objective, and that is that every American be covered for health care services; people shouldn't go without, because they can't afford to pay for it, and we have got to make this a high priority, because if we don't deal with this problem, not only are the injustices magnified, but the current system is something we can't sustain.

The costs are too great; we haven't been able to contain the costs, and therefore people go without coverage and those who do have coverage are paying exorbitant amounts for that coverage.

What we need to do is to figure out how to get to that point, whether it is the State level; whether it is the Federal level; whether we phase it in maybe with a pay or play until we get there; these are things that we are going to have to discuss.

But I want to commend each and every one of you for saying to us, this is the direction we have to take; this is a problem we can no longer ignore. And I thank you very much for your testimony.

Mr. SANDERS. Thank you, Mr. Chairman.

Mr. RUSSO. Thank you.

Ms. OAKAR. Thank you.

Mr. GIBBONS. Thank you.

Mr. WAXMAN. Our next panel consists of members who have introduced health care reform legislation that builds upon our existing employment based system. While these bills are unlike the pay or play approach that the Pepper Commission recommended, and that I sponsored, they do not contemplate the replacement of private employer based coverage with a public plan.

The gentleman from Ohio, Mr. Pease, sits on both the Budget and the Ways and Means Committee, he is the author of H.R. 1255, the Universal Health Insurance Act of 1991. The gentleman from Minnesota, Mr. Sabo, serves on both the Appropriations and Budget committees, he is the author of H.R. 2114, the Comprehensive Health Care Improvement Act of 1991. We are pleased to have both of you with us today.

Your prepared statements are going to be in the record in full. What we would like to ask you to limit the oral presentation to no more than 5 minutes. Mr. Pease, why don't we start with you?

STATEMENTS OF HON. DONALD J. PEASE (OHIO) AND HON. MARTIN OLAV SABO (MINNESOTA), REPRESENTATIVES IN CONGRESS

Mr. PEASE. Thank you very much, Mr. Chairman.

It is a pleasure to be with you today. I arrived a few minutes early and heard some of the previous testimony. It is clear from that testimony and from everything that is published that the key question before your subcommittee and the Congress is whether to go for a comprehensive all inclusive system, or to go to a system which targets those who are most in need, those who have no health insurance at all.

And within that choice, the next choice is whether to go with the existing health care delivery system and build upon that, or to go to a single payer system. My choice, which I first came to about 8 years ago was or is to use the existing health care delivery system and to target those who do not have any health insurance at all. And that is certainly what my bill does.

The Federal Government would seek bids from all health insurance purveyors on a set system or set regimen of benefits. The Federal Government would then award a contract to one of those companies in each State. That company would be guaranteed 60 percent of all of the business. Then a rule would be that the insurance company would have to take anybody who sought insurance, no exclusions whatsoever.

Then the Federal Government would issue to anybody who asked for it a voucher good for one of these insurance policies. The person would pay 6 percent of his or her income no matter what that income might be for the voucher. The remaining part of the cost, which would be considerable, would be picked up by the Federal Government.

Employers would be allowed to make use of this system if they wished to provide insurance for their own employees. If they fail to do so, we would have a tax on those employers, which would help to pay for the overall system. This in my view is the sort of thing which is most likely within the grasp of the Congress.

I have told people that I expect that we will have a national health system at some point, but that I don't know how to get from here to there considering the cost of a comprehensive system and considering the ferocious opposition that we would meet from the Federal fraternity, from the insurance industry, and from conservative groups. So I have chosen this approach for what I think is a workable way to deal within the existing system, and make health insurance accessible to those 35 or 37 million people who do not have it today.

I commend it to your attention.

Mr. WAXMAN. Thank you, very much, Mr. Pease. Very interesting approach.

[The prepared statement of Mr. Pease follows:]

STATEMENT OF CONGRESSMAN DON J. PEASE
HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
MONDAY, JULY 29, 1991

I would like to thank you, Chairman Waxman, for holding this hearing on Congressional long-term strategies for health care reform. I am pleased that you have seen fit to devote so much of the subcommittee's time to what has become the most pressing domestic issue of the decade. Health care costs come up as an issue at virtually every one of my town meetings in my district, and I receive dozens of letters and calls every month from patients as well as providers who are experiencing difficulties with some aspect of our health care system.

As you may know, I have long been interested in finding workable improvements to our country's system of health care. In fact, for the past several Congresses, I have introduced my own health care reform bill--the Universal Health Insurance Act. Basically, my bill, H.R. 1255, would serve to allow the unemployed and low-income workers greater access to health benefits. It would create affordable, comprehensive health coverage that citizens could buy into if they so desired. Building on the nation's existing system of private and non-profit health insurance, my plan would be non-coercive and would require reasonable payment from individuals receiving the insurance coverage.

My plan would be completely voluntary, and, although it would not be tied to employment, employers could offer insurance under my plan as an option to their employees who choose to participate. Employers would be encouraged to offer health insurance through the imposition of a new health plan employment tax, which would be waived for employers already offering adequate insurance plans to their employees. Individuals would be subject to sliding-scale premiums based on their ability to pay. The federal government would pay that portion of an individual's premium not covered by the sliding-scale payments. Funding for the subsidized premiums would derive in part from an increase in the federal excise tax on cigarettes.

Again, Mr. Chairman, I thank you for the attention that you are giving to the issue of health care reform, and I will look forward to our continued work in this field.

Questions and answers on H.R. 1255 follow.

QUESTIONS AND ANSWERS ON THE UNIVERSAL HEALTH INSURANCE ACT OF 1991

Why a Universal Health Insurance Act?

Access to health care today is increasingly dependent on health insurance. And although the health care needs of most Americans are adequately covered by employment-related plans or by government programs, an ever-increasing number are falling between the cracks of this system. Currently, about 15% of all Americans lack health insurance altogether, a 40% increase since 1980.

Individuals without health insurance are often forced to delay or avoid seeking needed medical help, thus worsening their conditions and causing easily preventable suffering and death. Often these individuals are forced to impoverish themselves in order to reach eligibility for public programs. Many of these people would be perfectly willing to pay for insurance if they could find insurance they could afford -- or that would enroll them. This is the kind of plan the Universal Health Insurance Act seeks to provide.

How Does the Universal Health Insurance Act Address These Problems?

The Pease plan would be open to everyone, regardless of income, work status, or health condition. Anyone who desires health insurance will be able to obtain a policy from a state insurance pool, operated by a private insurance company under contract to the federal government.

What Will the Insurance Plan Cover?

The plan will cover in-patient and out-patient hospital services and physicians' services; maternity, prenatal and postnatal care, diagnostic services; and catastrophic medical expenses. Coverage will be similar to health plans offered to most government and private sector employees.

How Much Will This Plan Cost An Individual?

The individual will pay a portion of the cost of the premium, based on a sliding scale -- 6% of the first \$10,000 of income and assets, 7% of the next \$10,000 and 8% of the next \$10,000. The income and assets determination will be made by an independent agency not associated with either the government or the insurance carrier.

How Will the Rest of the Premium Be Covered?

The portion of the premium not covered by the sliding scale payments will be picked up by the federal government. I propose to partially fund this by increasing the tax on cigarettes, a strategy supported by 83% of the American people in a recent survey.

Does Anyone Have to Buy This Insurance Plan?

No, absolutely not. The Pease plan is completely voluntary. There are no mandatory provisions either for employers or beneficiaries. If an individual wants health insurance, it is available at an affordable price, but the actual purchase decision remains the choice of the individual. The key is to give every American access to affordable health insurance.

How Will We Get People to Sign Up for the Plan?

The bill includes an outreach component as an important part of the Pease plan. A public information campaign will be vital to let the public know this insurance is available. It will also educate people about the importance of health insurance and the benefits available to those who enroll in the Universal Health Insurance Plan.

What About Self-Selection and Pre-Existing Conditions?

Certainly individuals with pre-existing conditions and individuals at risk for serious illness will sign up for this plan in large numbers. But without access to any insurance at all, these individuals will end up on Medicaid, with the American public paying the entire tab. With subsidized insurance, they help pay their own way, and some of the risk is covered by the pool. Also, insurance allows many people to get medical care earlier than they would without insurance coverage. This can keep serious conditions from developing, and can ease the severity of some illnesses that cannot be avoided.

How Will the Insurance Carriers Be Determined?

In each service area, the insurance companies will bid on the monthly cost of enrollments. The lowest bidder in a service area will become the "recognized" carrier and will be guaranteed at least 60% of the enrollment in that area for that year. The other insurance companies will be allowed to participate in the plan, but they must offer the same rates and conditions as the recognized carrier.

How Are Employers Affected By the Pease Plan?

Employers who offer health insurance to their employees will not be affected by the Pease plan. Employers who do not offer health insurance to their employees will have a choice between offering health insurance as a benefit or paying a new Health Plan Employment Tax, similar to the Federal Unemployment Tax (FUTA). If a health insurance option is available to employees, their employers will be exempt from the Health Plan employment tax. One way the employer can fulfill the health insurance option is to pay for the employee's insurance under the Pease plan.

How Does the Pease Plan Compare to Other Proposals for the Uninsured?

The Pease plan is not mandatory in any way, either for employers or employees. It is not tied to employment or to eligibility for any other program. It covers not just catastrophic care, but also the early medical care that can prevent catastrophic illness. The cost of the Pease plan is not excessive, the philosophical and political hazards are reasonable, and the mechanics of the proposed system appear practical. It looks like a winner to me, and I urge you to support it.

Mr. WAXMAN. Mr. Sabo.

STATEMENT OF HON. MARTIN OLAV SABO

Mr. SABO. Thank you, Mr. Chairman.

I appreciate this opportunity to appear on the question of access and cost of health insurance in this country. I think it is one of our most troubling problems today. Frankly, I think it has been one of the most troubling problems for a number of years. My interest in this issue has not really been sparked by my involvement in Congress, but rather in earlier years as a member of the State legislature when in the mid-1970's we passed a State catastrophic health insurance plan and a State pool. And we succeeded in those.

In my judgment, from that experience, I thought that there were several things we could do to substantially ease the problem of health care access we have in this country. In my judgment, there are two access problems. One is access for individuals who don't fit into the normal group insurance.

Second, is access for many small businesses who increasingly have a difficult time finding someone to offer insurance to them. In my judgment, the way we could have the quickest impact in making health insurance successful is one, mandating that employers offer insurance, which is what my bill does, for all employers of 10 or more; having State pools which offer access to individuals and to businesses which cannot buy normal group insurance coverage.

I frankly in my bill do not get into the question of premium split between employer and employee. I have no particular philosophical problem. If we get into it, we can pass it. On the other hand, my judgment is that even if we cannot move to legislating that premium split, there would be substantial benefit to mandating the offering of insurance by employers. My observation has been that lessens the political opposition from smaller employers, and I think the fact also is that the nature of the tax code where health insurance premiums are a nontaxable income to the employee, would quickly encourage the negotiation between an employer and employee to have the employer pay a portion of the premium without it being mandated.

I would also suggest, and we do in our bill, that we place greater emphasis on having a children's benefit option only within group insurance. The numbers are there; the balance being of the uninsured are children. Yet most group insurance plans offer the option of self-coverage and dependent coverage. Dependent coverage basically assuming an adult, plus kids. The premium split normally is employer pays more for the employee; less for dependent coverage.

The fact is today we have most couples, both parents are working. In many cases it is a single parent household. And they simply have to under our group insurance premium arrangements, have to buy coverage in effect for other adults, simply to cover their kids.

My judgment, we could substantially increase the access of kids to health insurance by making sure that the children's only option was included only on group insurance.

The question of cost control. I don't know any simple answer to that one. As we struggled in the mid-1970's in our legislature, the

same question was before us. Before you do anything, control costs. We did. We passed a certificate of need at that time on the State level.

In my own judgment, we made a mistake at the Federal level; I think my State made a mistake as they repealed certificate of need. That was relatively modest in comparison to some of the proposals I hear today. I thought that was good legislation, should have stayed on the books.

We did have extensive health care or health planning legislation on the books. That all disappeared in the early 1980's I thought that method of dealing with health care costs was helpful. I am convinced that, however, as we approach the future, and what we have in our bill, is a provision that requires States to establish a system for judging quality of health care.

If we are going to deal with that question, I think we have to put increased emphasis on having a mechanism whereby people can make judgments on quality of health care offered. If it is simply regulating costs, per bed, per fee, I don't think it gets to the heart of the problem. I think the evidence is there that somebody may have a more expensive per procedure charge, but if the effectiveness of that procedure is substantially better than other providers, clearly that is something that controls costs. I think the component of health care cost containment then has to be heavy emphasis on quality of care.

I heard the bell ring. Let me simply say that in our bill we also provide money and we raise money. We suggest that on the payroll tax for Medicare when we currently cut off at \$125,000, I know of no good reason why we should cut it off at \$125,000. We make all of earned income subject to that tax. It raises about \$4 billion. We say that is available for a new senior catastrophic plan. We do not try to define it; we leave that to your and other committees' judgments. I also know no reason why the Medicare tax should apply only to earned income and not to unearned income.

We apply that tax to all unearned income, raises about \$10 billion, refund that to the States on a per capital basis, about a little over \$40 per capita which they can use for two purposes. One, to subsidize the operation of a State pool to keep it competitive, and second, for the States to create a sliding fee scale program for low-income people to buy into the health insurance program.

We do not mandate State share, but we allow the States to supplement the Federal dollars.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Sabo.

[The prepared statement of Mr. Sabo follows:]

PREPARED STATEMENT OF HON. MARTIN OLAV SABO

Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to appear before you today as you examine the crisis in our nation's health care system and discuss various solutions.

By now, we all know about the 37 million Americans who have no health insurance and millions of others who lack adequate coverage. Who are these uninsured people? Eighty percent of them are employed or live in families of workers, 28% are under the age of 18, and over 60% live in families with incomes of less than \$20,000 per year. They are poor, young, and work for small firms.

Health insurance has become less available and less affordable in recent years. There are a variety of causes for this trend, but chief among them are the rising cost of health care and actions taken by the insurance industry to protect itself from those costs. The uninsured are less likely to seek needed medical attention until the problem becomes more severe and correspondingly more expensive. Who pays for the care then? We all do.

Governments subsidize hospitals to cover some of the cost of uncompensated care. Nevertheless, in 1986 hospitals lost an estimated \$7 billion because of unpaid bills - 5 percent of their expenses. Hospitals either absorb these costs by taking losses or pass them on in higher fees to those patients who have coverage. This way everyone pays for the millions of Americans who live without health insurance.

Last spring, I introduced legislation that would guarantee all Americans access to health insurance at group rates, help low-income persons buy coverage, and set aside funds for a new catastrophic health insurance program for senior citizens.

ACCESS

Our first priority should be to ensure access to coverage. My bill, the Comprehensive Health Care Improvement Act, requires businesses with 10 or more employees to offer coverage to their workers. The plans would have to cover dependents and provide an option for children-only coverage.

Under this proposal, firms would not have to pay the premiums and employees do not have to accept the coverage. Nonetheless, most people would have access to good coverage at group rates.

STATE POOLS

The legislation also requires states to establish state-wide insurance pools which could sell insurance to businesses as well as individuals. This would provide access to affordable insurance for those people who work for very small firms, the self employed, unemployed, and the otherwise uninsurable.

My proposal sets minimum standards for the plans businesses must offer. The state pools must offer at least two plans that meet the minimum standards, with one plan having higher deductibles.

LOW-INCOME ASSISTANCE PROGRAM

Even with universal access to group coverage, many individuals and families would still have a hard time paying insurance premiums. These people do not qualify for Medicaid but are still unable to afford insurance. In order to help these people, the bill establishes a low-income assistance program for individuals unable to pay their premiums. States could design programs that best meet their needs; such as sliding-fee scales, cost sharing, or total premium subsidies.

REVENUES

The Comprehensive Health Care Improvement Act raises the money necessary to implement the low-income assistance program and assist the state-run insurance pools in a sound and fair way. The legislation extends the 1.45% Medicare payroll tax to all unearned income (income from stock dividends, trust funds, interest, and other investments), raising approximately \$10 billion a year. The funds would be distributed to states on a per capita basis.

SENIOR PROGRAM

Rapidly escalating health care costs are hitting some of our senior citizens the hardest. For some, the available health insurance does not cover the cost of care following a catastrophic illness or a serious accident. The legislation I have proposed would also raise approximately \$4 billion for a fund to support a national catastrophic health insurance program for senior citizens. This program would be funded by applying the 1.45% Medicare tax to earned income in excess of \$125,000. Currently, earned income over \$125,000 is exempt from this tax.

QUALITY CARE

An important element of the bill is its requirement that states develop a method for judging the quality of health care provided. High quality care can substantially reduce health care costs. For example, the Center for Policy Studies in Minneapolis has determined that Medicare costs in Olmsted County, home of the Mayo Clinic, are 24% lower than the national average. This statistic is attributed to the quality of health care provided in the county. I believe one of the ways we are going to get a handle on the health costs in this country is to improve the overall quality of health care throughout the country.

SUMMARY

In summary, I believe my plan is sound, fair, and doable.

First, it is truly comprehensive. It provides access to good and affordable coverage for everyone.

Second, it has great flexibility. By using state pools and having the states run their programs, the bill takes advantage of existing expertise and bureaucracies. It allows states to tailor plans to fit their own particular circumstances.

Third, it would not be overly burdensome nor disruptive for businesses. In fact, it would help small businesses provide a much-needed benefit for themselves and their employees and help them retain healthier workers.

Lastly, it raises the necessary funds in an equitable manner.

We in Congress need to act. Rational and effective improvements in the U.S. health care system must be made. I believe my proposal approaches the problem of the uninsured in a measured and reasonable way, using the existing health insurance system wherever possible and appropriate. This bill is an affordable solution to one of our nations most pressing problems. I urge you to give it your most serious attention.

Mr. WAXMAN. As I understand your proposal, would you mandate insurance for the working people in this country, where they have an employer with 10 or more employees; is that correct.

Mr. SABO. That is right.

Mr. WAXMAN. And then for those who are not in the work force, would you have some money, but not spelled out entitlement as we understood the—

Mr. SABO. We would allow the States to have flexibility. They would have the option of buying into the State pool. In our State currently we have a State pool currently, since the mid-1970's. It is basically for people who are having health problems who can't purchase insurance for health reasons.

I simply would make that State insurance pool, make eligibility for it simply the inability or the fact that you want to buy in.

Mr. WAXMAN. So those would be individuals who are not in the work force?

Mr. SABO. That is right.

Mr. WAXMAN. Would that State pool cover those people with pre-existing conditions that are working or would they be covered by their jobs?

Mr. SABO. We provide that for preexisting conditions in the State pool that here is a 6-month waiting period. You virtually have to do that for adverse selection.

Mr. WAXMAN. Do you provide for insurance reforms?

Mr. SABO. No.

Mr. WAXMAN. Is it an employer mandate?

Mr. SABO. We provide for—I am not quite sure what you mean by insurance reform?

Mr. WAXMAN. In other words, would the employers be mandated to buy insurance?

Mr. SABO. Yes, they would be mandated to provide private insurance, and we define the minimum benefits which are rather comprehensive and would require the State pool to offer similar benefits.

But let me go to one other point in the operation. There are States with State pools, and generally a very difficult question is how you subsidize losses of that State pool to keep the premiums relatively competitive. The way the one works in our State is assessment on other insurers, which probably has some merit, but it involves a fundamental problem that the State cannot put that requirement on insurance policies covered by ERISA.

Namely, the self-insured, multiemployer contracts. And that is why we provide some of these Federal funds can be used for that operation of that State pool. Our experience frankly in Minnesota in the mid-1970's in dealing with this problem was that ERISA created all kinds of problems for us. It created problems for us in how to manage the operation of the State pool in sharing the extra risks there. We also wanted to mandate that at the point that you left an employer, that an option had to be to receive a conversion policy that had equivalent benefits.

Again, we could not do that for companies covered or plans covered under ERISA. We wanted to mandate extensive benefits in existing programs in terms of making sure that the private plans had catastrophic coverage. Again, we could not do it for ERISA covered

programs. So that ERISA ended up being a real roadblock for us in the State doing the things we wanted to do in the mid-1970's.

Mr. WAXMAN. And then what do you propose to do about the ERISA issue now, to have the States be able to reach all those plans?

Mr. SABO. I am not an expert on ERISA, and I just think if you move in any direction that solves State options which I think is the more practical direction to move in, if you move in the direction of State pools, if you have cost sharing in those State pools——

Mr. WAXMAN. You would leave it to the States then?

Mr. SABO. I would leave it to the States. I think you have to look at ERISA. In terms of State plans versus Federal plans, I tend to be skeptical about one uniform national plan. I think that would become very bureaucratic. I would much prefer State option.

Mr. WAXMAN. Mr. Pease, your proposal would be to have a pool in effect—a pooling arrangement that would be run by the private sector after negotiation with government. Is that a fair statement?

Mr. PEASE. Yes, certainly so, Mr. Chairman. The government would seek bids from private insurance companies to provide to any individual a certain level of medical benefits in a standard hospitalization policy, and the government would award the bid and the companies would provide the coverage.

Mr. WAXMAN. Neither of you mandate that people get coverage; is that right? If people decided not to get coverage, that is their choice?

Mr. PEASE. That is correct, at least in my case it is.

Mr. SABO. I don't know how you can provide the opportunity. I am not sure how you require them to do it if they choose not to. I suppose it is true under the existing plan; it would be under this plan.

I might say that frankly one of the things as I was looking at this issue again this year, I discovered that actually in terms of COBRA we have done a number of things which I think most folks are not aware of. One of the other groups that tends to be highly underinsured are young adults who have lost their group eligibility under their parent's plan.

I discovered that I think it is for 3 years that they could get those—continue those same benefits by paying additional premiums and have equivalent benefits. My sense is that lots of people are not aware of that option.

Mr. WAXMAN. Thank you very much.

Mr. Dannemeyer.

Mr. DANNEMEYER. I have no questions of these two distinguished gentlemen. Thank you.

Mr. WAXMAN. Let me just ask one last question.

What do you do with the people that aren't insured? How should we deal with the cost of care for those people who decide not to insure themselves?

Mr. SABO. I am not sure. I do not know a good answer to that. If somebody refused to for a variety of reasons, I assume they are ultimately responsible for their bills. If they have no assets, then in some way the public becomes involved. Frankly, that was one of the reasons in Minnesota in the mid-1970's we passed a catastroph-

ic plan that applied to everyone, but the deductibles were very, very high.

I think as I recall they were 40 percent of the first \$15,000 of income, 50 percent between \$15,000 and \$25,000, and 60 over \$25,000, and that plan ensured that nobody was totally annihilated by major illness, but the deductibles were so high that it encouraged people in effect to have other insurance, but there was this backup plan in case someone didn't or that the costs went beyond, substantially beyond the costs of their normal coverage.

Mr. PEASE. Mr. Chairman, I think the medical costs of those who choose not to participate in this system certainly will be borne the same way they are now, in the emergency room, through private payors, bill collectors, et cetera. I would hope that a relatively small percentage of people who choose—would choose out of the system. But I do think as Mr. Sabo said that some element of free choice is really essential to the sort of thing that we have in mind.

Mr. WAXMAN. I want to thank both of you for your very interesting proposals and your presentation to us. We look forward to working with you.

Mr. SABO. Thank you.

Mr. PEASE. Thank you.

Mr. WAXMAN. Our final panel was to consist of two of our colleagues. Unfortunately one of them will not be able to be with us because his plane is delayed, but we do have with us our colleague, Representative Johnson from Connecticut who is a member of the Committee on Ways and Means and has introduced H.R. 1565, the Health Equity and Access Reform Today Act of 1991. We want to welcome you to our subcommittee hearing today.

Your prepared statement we will have in the record in full. We would like to ask if you would to limit the oral presentation to 5 minutes. And Mr. Grandy, Representative Grandy, who is also a member of the Committee of Ways and Means introduced H.R. 1230, The Universal Health Benefits Empowerment and Partnership Act of 1991, and unfortunately he is not able to be with us, but without objection, we will have his prepared statement in the record.

[The prepared statement of Mr. Grandy follows:]

PREPARED STATEMENT OF HON. FRED GRANDY, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF IOWA

Mr. Chairman and members of the Committee, I appreciate this opportunity to testify on one of the most important policy decisions confronting the United States Congress. Specifically, ensuring affordable, quality, health care coverage for all Americans.

Today, I am here to provide an overview of health care legislation I originally introduced in the 101st Congress and have reintroduced in the 102nd Congress as H.R. 1230. The legislation is known as the HEAL bill—"Healthcare Empowerment and Access Legislation".

HEAL offers a carrot and stick approach that provides a window of opportunity for the private sector. Through a phased in approach, HEAL provides incentives for private and public-private partnership arrangements. The key to this approach is flexibility. Ideas come from the bottom up and a national health care strategy is created through a confederation of states approach.

Specifically, the carrots contained in this bill are: (1) a phased in 100 percent tax deduction for the self-employed and their employee; (2) preemption of state health benefit mandates; (3) incentives for small businesses to group together and offer soundly financed multiemployer health plans through 501(c)(9) tax incentives; (4)

ERISA preemption of state barriers to managed care options to encourage competition, innovation of cost-control approaches, and quality review; (5) outcomes research to educate consumers who purchase health care; and (6) treatment practice guidelines that would work to reduce unnecessary services and malpractice costs.

If these incentives are not effective after a given period of time, the stick would swing into effect. Employers who were not attracted to the carrots would be obligated to offer a basic group health package. Employers would be encouraged, but not required, to contribute to such plans. To insure universal access, a state based nonprofit corporation would serve as a backup only in the event group coverage for the employer's employees is rejected by a group health coverage provider. Individuals who would be denied access to group health coverage because of uninsurability or material preexisting conditions, would be eligible for coverage either under an employer based plan, a state based nonprofit corporation, or an alternative fall-back system. This alternative would be established by the private sector voluntarily, or by the state.

Again, the key to this approach is flexibility. Local governments would be given the opportunity to build on current successes. States would be used as laboratories of experimentation. A confederation of States approach is offered as the United States national health care strategy.

Mr. Chairman, this committee has heard various approaches to expanding access and ensuring affordable health care coverage for all Americans. These range from proposals to eliminate the current system and replace it with a Canadian style system, as advocated by my colleague Marty Russo, to proposals to eliminate the current tax exemption provided businesses for their health care expenses and replace it with an individual tax credit, as advocated by the Heritage Foundation. My proposal clearly comes in well to the right of the Russo approach and left of the Heritage approach. On a spectrum with these two approaches as the respective left and right ends, my approach comes in on the fifty yard line, building upon the very best aspects of our current system and providing the flexibility necessary to address the deficiencies within that system.

Thank you once again for holding these hearings and providing me with this opportunity. I would be happy to answer any questions at this time.

Mr. WAXMAN. Mrs. Johnson.

STATEMENT OF HON. NANCY L. JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mrs. JOHNSON. Thank you very much, Mr. Chairman for holding these hearings and for giving members an opportunity to share our thoughts with you. I think, as we approach this larger discussion, it is very, very important to take into account the experience that we have already had at the national level in controlling health care costs. The VA system is a perfect example of Federal control and Federal cost containment.

In the VA system, we have controlled costs through the budget mechanisms and ultimately by eliminating a whole group of veterans who had access to that system. In the Medicaid system, we have controlled costs by reducing fees so dramatically that, without any question at all, access has been severely limited and quality compromised.

As we go into this discussion, I think the experience of how we as a government have sought to provide care and then sought to control costs is very relevant.

Before I get into my comments on solutions, let me make two brief comments that I enlarge upon in my testimony on other ideas that are out there. First of all, the mandatory pay or play system. In a Nation with a vital small business sector where the small businesses are the job drivers of our economy, it is very important that we not compromise the ability of people to create small businesses and instead face them to go out of business.

If we impose on them a heavy cost, we will certainly have a very dramatic impact on the structure and shape of our small business sector. I personally believe there are options to mandating an insurance responsibility on small business, particularly when it is very clear that small businesses would love to provide health insurance for their employees.

It is a disadvantage not to be able to do that in terms of competing in the labor market. They don't provide health insurance for the same reason many small businesses that did provide health insurance no longer do; it is simply too expensive and it is not possible to predict the cost growth in that benefit.

And therefore, employers are reluctant to get into the business to begin with, even if they could afford it right now. They are afraid that in 2 or 3 years they will have to withdraw that benefit and they don't want to have to be put in that position.

I think it is important to recognize that small business would love to provide health benefits. And they don't for good reason. We ought to be very careful before we mandate on them an expense that we cannot control and one that they certainly cannot control and that will clearly be the difference between being alive and being dead as a small business.

So, the pay or play system, I think, raises some very serious issues for us. Furthermore, it creates some inequity. Under Senator Mitchell's pay or play provision, if my husband works for someone and I work for someone, I cannot have access to his program, even if it is better than mine. And if my employer decides to pay instead of play, then I am part of the State minimum benefit pool which may not have very good benefits, particularly for women and children, but I will no longer have the right to be covered under his insurance.

As I think there are some serious problems with the pay or play approach, I also think there are serious problems with the Canadian approach. We must move carefully, because these issues are of profound importance to us and will have an enormous impact on the structure of our economic activity, as well as on our health care system.

I believe the debate on these issues will be time consuming, years in coming, and that, in fact, there are larger issues that prevent radical reform from happening now. But there are seven things in my estimation that we can do now and that we must, in good conscience do now, because they will materially expand access. I don't think we can afford not to do the things that we know will expand access for the uninsured.

In addition, they will turn the cost drivers in a different direction. We know that. We don't know how much when we do these things systematically, but we have good reason to believe that the effect will be significant. In 3 years or so when the national debate matures, we will be able to see the consequences of the immediate actions that we have taken to affect access and costs and therefore, be in a much better position, to make judgments about what further macro moves we want to take.

By that time, we may be talking about 20 percent of our economy. You don't alter the rules that govern 20 percent of the Nation's economic activity without some trepidation. I just want to hit

some high points on the seven things that I want to recommend because you know a lot about them already. Reform of the small group health insurance market is—in my estimation—doable this year. We know enough about it and it clearly would create access for about two-thirds of the uninsured who are working on their dependents, and especially the one-third that makes more than 200 percent of the poverty level.

The form that the small group takes in my bill, if I could infringe on my colleague, Mr. Grandy's time, because my small—

Mr. WAXMAN. I understand he wanted to yield to you, so go ahead.

Mrs. JOHNSON. Thank you.

My bill is different in terms of its reform for the small business sector in two regards. First of all, it is the only one that creates a competitive market. And I think that is important. If we are going to have small group reform, we ought not to have one plan out there, we ought to have a way of creating a variety of plans so there will be some choice.

Second, in my small group reform, the role of the Federal Government is not unlike it is in the Medigap insurance reform proposal adopted a year ago. It is the Federal Government that says these plans must meet these criteria, and one of them is limiting the right to exclude for preexisting conditions. Limiting rate variations, guaranteeing renewal, guaranteeing eligibility, requiring public disclosure are other criteria.

So, I think some of the problems that most plague that market and most frustrate our constituents should be addressed as part of a small group reform. The model of Medigap reform is an important one.

Third, I want to call your attention to the bill that Rod Chandler and I introduced that uses the COSE [Counsel of Smaller Enterprises] model in Cleveland to allow groups of small employers to band together and, thereby, as a larger group lower rates by bargaining costs.

Our bill would relieve them of premium taxes; our bill would allow them to accrue those 30 percent reductions in administrative costs and go beyond that because they would be also able to use the ERISA exemption and write their own plan.

So the combination of the Chandler-Johnson-COSE bill and the Johnson-Chandler small business reform bill creates the possibility of reducing, by at least 50 percent, the cost of small group health insurance in America. I think that is a formidable challenge for us to look at.

Fourth, tax code reforms of the self-employed would be treated the same as larger employers.

Fifth, only rewarding health insurance plans that promote smart buying is another major change that we could make this year.

Sixth, expanding community health care centers is terribly important, as is tort reform. Malpractice premiums are eating up a lot of our community health center money.

Let me just say one extra word here on expanding community health centers because you asked my colleague, Mr. Sabo, how to deal with the uninsured under his program. Since I don't mandate purchasing insurance under my bill, but instead mandate that

small businesses must educate their employees about this new market of small group plans, there would be some businesses that don't choose or can't afford to contribute to health insurance. My vision of the expansion of the community health centers is not just expansion. I see a public health system out there in the future such that there wouldn't be a town whose people who can't afford insurance wouldn't have access to care. The centers can charge on a sliding scale fee. We should have some way other than the emergency room where people throughout America's rural and urban communities can always reach basic health care. And I think our community health center system demonstrates the power of such an approach to really create universal access.

[The prepared statement of Mrs. Johnson follows:]

STATEMENT OF THE HONORABLE NANCY L. JOHNSON
BEFORE THE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES

"COMPREHENSIVE PROPOSALS TO EXPAND ACCESS TO
HEALTH BENEFITS, CONTROL THE COST OF HEALTH
CARE, AND PROVIDE FOR
OTHER HEALTH SYSTEM REFORMS"

July 29, 1991

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU AND YOUR COLLEAGUES ON THE ENERGY AND COMMERCE'S SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT TO DISCUSS HEALTHCARE REFORM PROPOSALS THAT WILL ADDRESS THE CRITICAL ISSUES FACING OUR NATION TODAY--THE "TRILOGY" OF ACCESS, COST, AND QUALITY.

AS WE ENTER INTO THIS DISCUSSION, IT IS IMPORTANT TO REMEMBER TO BE PROUD THE UNITED STATES OFFERS THE HIGHEST QUALITY MEDICAL CARE IN THE WORLD, THE BEST TECHNOLOGY AND PHARMACOLOGY, AND THE MOST SOPHISTICATED MEDICAL PROVIDERS. BUT WE MUST BE ASHAMED OF THE SYSTEM'S FAILURE TO SERVE MILLIONS OF WORKING AND NON-WORKING POOR, AND APPALLED AT THE SPIRALING COSTS THAT INCREASINGLY THREATEN THOSE WITH, AS WELL AS THOSE WITHOUT, HEALTH INSURANCE.

TWENTY-EIGHT MILLION WORKERS AND THEIR DEPENDENTS ARE UNINSURED AND INELIGIBLE FOR PUBLICLY-FUNDED CARE. ANOTHER SIX MILLION INDIVIDUALS AND THEIR DEPENDENTS LACK BOTH WORK AND ELIGIBILITY FOR PUBLICLY-FUNDED CARE. THIS MEANS LOW INCOME PREGNANT WOMEN GO WITHOUT PRENATAL CARE AND MILLIONS OF CHILDREN DON'T RECEIVE BASIC IMMUNIZATIONS, TO GIVE JUST TWO EXAMPLES OF THE SEVERITY OF THE PROBLEM.

POLL AFTER POLL SHOW HOW CONCERNED THE PUBLIC IS WITH RISING HEALTHCARE COSTS. IT IS NOT THE UNINSURED THAT ARE DRIVING THE PUBLIC'S DESIRE FOR HEALTHCARE POLICY REFORM. IT IS RISING HEALTHCARE COSTS AND THE THREAT THEY POSE TO PEOPLES' CONTINUED ACCESS TO HEALTH INSURANCE. THOSE THAT CURRENTLY HAVE INSURANCE FEAR LOSING IT. ACCESS TO HEALTHCARE IS NO LONGER A POOR PERSON'S WORRY. IT IS INCREASING EVERYONE'S CONCERN.

THE COST CRISIS IN OUR HEALTHCARE SYSTEM DID NOT HAPPEN OVERNIGHT. OUR BEST EFFORTS OVER THE PAST DECADE TO STEM HEALTHCARE COST INCREASES HAVE MET WITH FAILURE. GOVERNMENT PRICE FIXING IN MEDICAID, MEDICARE, AND THE VA SYSTEM HAVE PERIODICALLY APPEARED TO CONTROL COST SUCCESSFULLY, BUT THAT HAS ALWAYS PROVED TO BE SHORT-TERM.

IN THE VA SYSTEM WE HAVE SUCCEEDED IN CONTROLLING COSTS--BUT ONLY BECAUSE WE HAVE DEFINED A WHOLE GROUP OF VETERANS AS INELIGIBLE. IN MEDICAID, WE SIMPLY REDUCED FEES SO DRAMATICALLY THAT ACCESS TO CARE BECAME LIMITED AND QUALITY SEVERELY COMPROMISED.

HEALTHCARE COSTS CONTINUE TO RISE AT RATES SUBSTANTIALLY HIGHER THAN THE

RATE OF INFLATION DESPITE ALL OF THE COST CONTROL MEASURES WE HAVE TAKEN. U.S. HEALTHCARE COSTS ARE NOW OVER 12 PERCENT OF OUR GROSS NATIONAL PRODUCT (GNP) AND, BY SOME ESTIMATES, WILL RISE TO 20 PERCENT OF GNP IN THE NOT-TOO-DISTANT FUTURE. THERE IS HARDLY ANYTHING WE DO ON THE WAYS AND MEANS COMMITTEE WHERE ONE STROKE OF THE PEN AFFECTS 20 PERCENT OF THE ECONOMIC ACTIVITIES IN OUR NATION!

RADICAL REFORM IS NOT IMMINENT, IN MY OPINION. IT IS ALSO NOT APPROPRIATE. THERE ARE MANY TECHNICAL, STRUCTURAL AND IDEOLOGICAL ISSUES THAT MUST BE ADDRESSED. MAKING RESPONSIBLE AND CONSTRUCTIVE CHANGES AFFECTING UP TO ONE-FIFTH OF OUR NATION'S ECONOMY TAKES TIME. BUT THERE ARE REFORMS WE KNOW ENOUGH ABOUT TO ADOPT NOW. I FEEL ABLE, AS I KNOW FRED GRANDY DOES, TO DIFFERENTIATE BETWEEN THOSE THINGS WE CAN DO TODAY THAT WILL MAKE A REAL DIFFERENCE IN PEOPLES' LIVES IN TERMS OF ACCESS AND CONTROLLING COST AND THOSE IDEAS THAT ARE NOT-YET RIPE. IT WILL TAKE YEARS OF DEBATE ON THE CONSEQUENCES AND TRADE-OFFS ASSOCIATED WITH THE BROADER PROPOSALS BEFORE WE CAN MAKE THESE MORE SYSTEMIC CHANGES.

FOR EXAMPLE, THE LEVEL OF KNOWLEDGE OF WHAT IT MEANS TO BE UNDER THE CANADIAN SYSTEM IS VERY, VERY LOW, AND--IN PARTICULAR--THE SENSITIVITY OF THE TRADEOFFS IS HARDLY THERE AT ALL. IT IS NOT ENOUGH TO ADVOCATE A SINGLE-PAYER SYSTEM LIKE CANADA'S AND NOT ADDRESS SUCH DIFFICULT CONSEQUENCES AS THOSE EXEMPLIFIED IN CANADA'S APPROACH TO LITHOTRIPSY TREATMENT FOR GALL STONES. THE AVERAGE LENGTH OF TIME A CANADIAN MUST WAIT FOR EMERGENCY LITHOTRIPSY IS 90 DAYS; TWO YEARS IS THE WAITING PERIOD FOR ELECTIVE LITHOTRIPSY!

THE MANDATORY PAY OR PLAY SYSTEM RAISES EQUALLY TROUBLESOME QUESTIONS. SMALL BUSINESSES CREATE THE MAJORITY OF NEW JOBS IN AMERICAN AND ARE STILL OUR MOST INVENTIVE SECTOR. PAY-OR-PLAY PLANS WILL AFFECT THE VITALITY OF THE SMALL BUSINESS SECTOR WITH SERIOUS CONSEQUENCES FOR OUR ECONOMY. FURTHER, FOR MANY TWO-WORKER FAMILIES, THIS POSES A REAL THREAT FOR THE LEVEL OF COVERAGE FOR ANY SPOUSE WHO WORKS FOR A COMPANY THAT CHOOSES TO PAY INSTEAD OF PLAY. SENATOR MITCHELL'S BILL WOULD REQUIRE WORKERS TO ACQUIRE HEALTH INSURANCE THROUGH THEIR EMPLOYER. IN TWO-WORKER FAMILIES IT IS THE WIFE WHO USUALLY HAS THE LOWER PAYING JOB AND, PRESUMABLY, WOULD ALSO HAVE THE LESS-RICH BENEFIT PLAN. AND IF HER EMPLOYER CHOSE NOT TO OFFER INSURANCE AT ALL, SHE WOULD AUTOMATICALLY BE PUT IN THE PUBLIC PLAN!

LET ME NOW TURN TO DESCRIBING THE KIND OF CHANGES THAT I BELIEVE WOULD BOTH TAKE US A LONG WAY IN ADDRESSING THE PROBLEMS OF ACCESS, COST AND QUALITY AND GIVE US THE TIME I FEEL IS NECESSARY FOR THE PUBLIC AND THEIR ELECTED OFFICIALS TO IDENTIFY REFORMS THAT WILL PREPARE US FOR THE 21ST CENTURY.

INTRODUCED BY MYSELF AND ROD CHANDLER (R-WA), THE HEALTH EQUITY AND ACCESS REFORM TODAY (HEART) ACT (H.R. 1565) WOULD REFORM THE SMALL GROUP HEALTH INSURANCE MARKET THEREBY MAKING LOW-COST, BASIC OFFICE AND HOSPITAL COVERAGE AVAILABLE TO THE NEARLY 20 MILLION WORKERS AND THEIR DEPENDENTS WITHOUT HEALTH INSURANCE--ONE THIRD OF WHOM HAVE INCOMES OVER 200 PERCENT OF POVERTY.

COSTLY STATE MANDATES WOULD BE OVERRIDDEN THROUGH THE PROVISIONS IN MY BILL IN ORDER TO MAKE AN INEXPENSIVE BASIC PLAN AVAILABLE TO SMALL BUSINESSES. IN ADDITION, OUR PROPOSAL IS THE ONLY PROPOSAL OUT THERE THAT WOULD ALLOW

COMPETITION AMONG BASIC INSURANCE PLANS SINCE IT WOULD WAIVE STATE BENEFITS MANDATES FOR ANY PRODUCT IN THE SMALL GROUP MARKET AS LONG AS THOSE PLANS:

- O DON'T EXCLUDE FOR PRE-EXISTING CONDITIONS AFTER INITIAL ACCEPTANCE,
- O LIMIT RATE INCREASES,
- O ASSURE GUARANTEE RENEWAL EXCEPT FOR NON-PAYMENT OF PREMIUMS, AND
- O CONFORM TO CERTAIN PUBLIC DISCLOSURE AND CERTIFICATION REQUIREMENTS.

ANOTHER APPROACH TO REFORMING THE SMALL GROUP HEALTH INSURANCE MARKET IS CONTAINED IN A BILL THAT ROD CHANDLER INTRODUCED AND I CO-SPONSORED CALLED THE SMALL EMPLOYER HEALTH INSURANCE INCENTIVE ACT OF 199, (H.R. 2453). THIS BILL IS MODELED AFTER THE COUNCIL OF SMALLER ENTERPRISES (COSE) OF CLEVELAND, OHIO. COSE IS A PURCHASING GROUP THAT MAKES HEALTH INSURANCE AVAILABLE AND AFFORDABLE TO 10,000 SMALL EMPLOYERS AND OVER 120,000 EMPLOYEES AND THEIR DEPENDENTS.

BECAUSE OF ITS ADMINISTRATIVE EFFICIENCIES AND PURCHASING POWER, PREMIUM RATES FOR COSE INCREASED BY ONLY 34 PERCENT BETWEEN 1984 AND 1990, COMPARED WITH A 154 PERCENT INCREASE FOR COMMERCIAL INSURANCE RATES DURING THE SAME PERIOD. THESE COST SAVINGS HAVE ENABLED APPROXIMATELY 2,000 SMALL EMPLOYERS IN THE CLEVELAND AREA TO OFFER EMPLOYEE HEALTH INSURANCE THAT DID NOT DO SO BEFORE JOINING COSE.

TO ENCOURAGE THE FORMATION OF SMALL EMPLOYER PURCHASING GROUPS, STATE-MANDATED HEALTH BENEFITS, STATE TAXES ON HEALTH INSURANCE PREMIUMS, AND STATE LAWS PROHIBITING CERTAIN TYPES OF MANAGED CARE ACTIVITIES WOULD BE WAIVED. THESE GROUPS MUST HAVE AT LEAST 100 EMPLOYERS, EACH OF WHOM HAS NO MORE THAN 100 MEMBERS AT THE TIME THEY JOIN THE GROUP.

WHAT ELSE COULD WE DO RIGHT NOW? WE CAN REFORM OUR TAX CODE TO DO TWO VERY IMPORTANT THINGS. FIRST OF ALL, TO ALLOW THE SELF-EMPLOYED THE SAME TAX BENEFITS WE ALLOW EMPLOYERS BY GIVING THEM 100 PERCENT DEDUCTIBILITY FOR PREMIUMS. BOTH THE HEART AND COSE BILLS WOULD DO THIS.

AND SECOND, WE CAN CHANGE OUR CURRENT TAX LAWS SO THAT WE ENCOURAGE THE "SMART BUYING" OF HEALTHCARE. CONSUMERS MUST BE SENSITIVE TO THE COST OF THEIR MEDICAL CARE. WE SHOULD ONLY BE PROVIDING TAX INCENTIVES FOR PLANS THAT HAVE A MANAGED CARE COMPONENT OR A CO-PAY STRUCTURE OR MEETS CERTAIN OTHER CRITERIA SPELLED OUT IN THE HEART BILL. THAT WAY, YOU DRIVE THE WHOLE PRIVATE SECTOR TOWARD THINKING MANAGED CARE, TOWARD THINKING SMART PURCHASING. BY DOING THIS YOU MATERIALLY ALTER THE CURRENT INCENTIVES IN THE SYSTEM. THIS IS PROBABLY THE MOST PROFOUNDLY EFFECTIVE THING THAT WE COULD DO TO REDUCE THE RATE AT WHICH COSTS ARE INCREASING AND EXPAND ACCESS TO HEALTHCARE.

THE HEART BILL ADDRESSES THE NEED FOR MAINTAINING AND ENHANCING OUR QUALITY OF CARE BY SETTING GUIDELINES FOR A COMPREHENSIVE ELECTRONIC UTILIZATION REVIEW SYSTEM FOR OUR HOSPITALS. IT WILL TAKE A WHILE TO GET THIS PATIENT DATA ON LINE, BUT QUALITY 2000, AS THIS INITIATIVE IS CALLED, WILL ENABLE HOSPITALS AND OTHERS TO COLLECT AND MAKE USE OF THE INFORMATION SO CRITICAL TO ASSURING VALUE

FOR EACH HEALTH DOLLAR SPENT AND TO ELIMINATING UNNECESSARY TESTING AND PROCEDURES.

FOR THOSE INDIVIDUALS AND FAMILIES WHO COULD NOT OBTAIN AFFORDABLE HEALTHCARE COVERAGE EVEN UNDER THE REFORMS IN THE HEART OR COSE BILLS, THE HEART BILL WOULD EXPAND COMMUNITY HEALTH CENTERS (CHCs) TO ASSURE NEIGHBORHOOD ACCESS TO THE LOW-INCOME UNINSURED. I DON'T HAVE TO TELL THE MEMBERS OF THIS COMMITTEE THAT EVEN WITH THE RECENT SERIES OF ELIGIBILITY EXPANSIONS IN MEDICAID, FULLY 61 PERCENT OF FAMILIES BELOW 200 PERCENT OF THE FEDERAL POVERTY LEVEL REMAIN UNINSURED AND INELIGIBLE FOR MEDICAID. THESE CENTERS WOULD BRING QUALITY PHYSICIAN AND OUTPATIENT CARE DIRECTLY TO THOSE MOST IN NEED. THEY WOULD PROVIDE THE LINCHPIN FOR AN ESSENTIAL NEIGHBORHOOD NETWORK THAT COULD OFFER FAMILY SUPPORT SERVICES, DRUG TREATMENT SERVICES AND ACCESS TO SUCH IMPORTANT PREVENTABLE HEALTH SERVICES AS WIC.

AND SINCE THESE CENTERS OFFER CARE TO ALL THROUGH SLIDING-SCALE FEES, COMMUNITY HEALTH CENTERS CAN ASSURE HEALTHCARE ACCESS TO EVERYONE IN THE NEAR FUTURE IF ALLOWED TO EXPAND. A SET-ASIDE FOR RURAL AREAS WOULD ASSURE THAT COMMUNITY HEALTH CENTERS ARE AN INTEGRAL PART OF ANY RESTORATION OF THE FAMILY MEDICAL CARE INSTITUTIONS SO ERODED IN OUR RURAL AREAS. THUS, A GREATLY EXPANDED CHC GRANT PROGRAM COULD REACH THOSE INDIVIDUALS THE SMALL GROUP INSURANCE MARKET REFORMS COULDN'T REACH.

AN EQUALLY IMPORTANT REFORM IS THAT THE HEART BILL WOULD SHIELD COMMUNITY HEALTH CENTERS FROM EXORBITANT LIABILITY INSURANCE PREMIUMS. THIS IS THE SAME CHANGE THAT REPRESENTATIVE RON WYDEN'S BILL, H.R. 2239, WOULD MAKE. ONE FIFTH OF THE MONEY IN THIS PROGRAM IS GOING TO PAY FOR LIABILITY PREMIUMS DESPITE THE FACT THAT ALMOST NO MALPRACTICE CLAIMS HAVE BEEN FILED AGAINST THESE CENTERS. THIS REFORM ALONE WOULD FREE UP \$58 MILLION A YEAR IN DIRECT FEDERAL SUPPORT, ENSURING THAT AN ADDITIONAL ONE-HALF MILLION INDIVIDUALS COULD BE SERVED.

THERE IS ONE LAST BILL THAT I WOULD LIKE TO MENTION, H.R. 1004, THE ENSURING ACCESS THROUGH MEDICAL LIABILITY REFORM ACT. MALPRACTICE REFORM IS AN AREA WE HAVE TO FOCUS ON. I KNOW MY REMARKS WILL BE "PREACHING TO THE CHOIR" BECAUSE THIS COMMITTEE IS INTIMATELY INVOLVED IN MALPRACTICE ISSUES. BUT I DO WANT TO SAY THAT MALPRACTICE REFORM IS NOT JUST A QUESTION OF COST, ALTHOUGH THAT IS IMPORTANT. IT IS ALSO A QUESTION OF ACCESS. IT IS A QUESTION OF ACCESS TO JUSTICE BECAUSE OUR CURRENT MALPRACTICE SYSTEM IS TOO EXPENSIVE FOR THE MAJORITY OF VICTIMS. MALPRACTICE REFORM IS ALSO A QUESTION OF QUALITY. IF THE SMALL MALPRACTICE CASES DON'T GET INTO THE SYSTEM, YOU CAN'T IDENTIFY POOR PROVIDERS EARLY IN THEIR CAREER. INSTEAD, WE HAVE TO WAIT UNTIL THEY MAKE MORE SERIOUS MISTAKES BEFORE WE CAN GET THEM OUT OF THE SYSTEM.

MY BILL WILL MAKE IT EASIER AND CHEAPER TO RESOLVE MALPRACTICE CLAIMS SO THAT MORE PEOPLE WILL HAVE ACCESS TO FAIR COMPENSATION. STATES ARE CALLED UPON TO MOVE TOWARD ALTERNATIVE FORMS OF RESOLVING DISPUTES, SUCH AS MEDIATION, VOLUNTARY OR BINDING ARBITRATION, OR EARLY OFFER AND RECOVERY MECHANISMS. BY LIMITING ATTORNEYS' FEES AND PLACING CAPS ON NON-ECONOMIC AWARDS, PHYSICIANS AND PATIENTS WILL BENEFIT FROM A REDUCTION IN MALPRACTICE INSURANCE PREMIUMS. AND WE ALL WILL BENEFIT FROM THE REDUCTION IN DEFENSIVE MEDICINE. SOME ESTIMATE THAT DEFENSIVE MEDICINE COSTS AS MUCH AS \$30 BILLION A YEAR.

THERE ARE NO EASY SOLUTIONS TO OUR HEALTHCARE CRISIS. BUT IT IS IMPERATIVE THAT WE MOVE NOW TO CORRECT THE ACCESS, QUALITY AND COST PROBLEMS WITH OUR HEALTHCARE SYSTEM IN AT LEAST THE WAYS THAT ARE OBVIOUS AND WOULD NOT DESTROY THE REMARKABLE STRENGTHS OF OUR SYSTEM. THE CHALLENGE BEFORE US IS HOW TO ASSURE THAT THE 34 MILLION AMERICANS CURRENTLY WITHOUT HEALTH INSURANCE HAVE ACCESS TO QUALITY CARE, THAT THE COST OF THAT CARE BE AFFORDABLE -- TO THE INDIVIDUAL, TO THE EMPLOYER, AND TO THE TAXPAYER -- AND THAT THE QUALITY OF CARE REMAIN HIGH. THIS MEANS MAKING SURE THAT THE CARE IS APPROPRIATE TO THE PROBLEM, THAT THE RIGHT NUMBERS AND TYPES OF PROVIDERS AND TECHNOLOGIES ARE AVAILABLE, AND THAT THOSE PROVIDERS ARE QUALIFIED TO DO THE JOB. AND LASTLY, THE SYSTEM MUST MAINTAIN THE QUALITY AMERICA IS WORLD RENOWN FOR.

IN CONCLUSION, MY MESSAGE TO YOU IS THAT THERE ARE ACTIONS THAT WE CAN TAKE NOW. WHILE THE NATIONAL DEBATE CONTINUES, WE MUST IN GOOD CONSCIENCE, DO THOSE THINGS THAT ARE CLEARLY DOABLE TO INCREASE ACCESS AND CONTROL COSTS. EXPANDING OUR COMMUNITY HEALTH CENTER SYSTEM, MAKING AFFORDABLE HEALTH INSURANCE AVAILABLE TO SMALL EMPLOYERS AND REFORMING OUR TAX CODE AND LIABILITY LAWS WILL SIGNIFICANTLY ADDRESS OUR ACCESS AND COST CONTROL GOALS.

THANK YOU AGAIN FOR THE OPPORTUNITY TO TESTIFY TODAY. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE.

E&C_7-29

Mr. WAXMAN. Mrs. Johnson, let me ask you some questions.

Mrs. JOHNSON. The last point is liability reform.

Mr. WAXMAN. So you have tax code changes, liability reform, community health centers to pick up some of the public needs that are not maybe otherwise covered, but the heart of what you are suggesting is reform of the insurance market.

Mrs. JOHNSON. That is not the heart of it. It is the combination of the reform of the insurance and expansion of the community health centers. The two together can reach everyone.

Mr. WAXMAN. All right. Now let's look at the insurance reform aspect of it. You would eliminate the underwriting of insurance, private insurance, wouldn't you? No preexisting conditions exclusions?

Mrs. JOHNSON. Yes.

Mr. WAXMAN. You set up standards that all of them would have to meet. You would say that they have to cover everybody who is willing to pay the same fee; is that correct?

Mrs. JOHNSON. Not the same fee because it would be a competitive market so that there would be a number of basic plans that they could choose from.

Mr. WAXMAN. But if a person wants to choose a particular plan, they would be charged more because they were a higher risk?

Mrs. JOHNSON. Correct.

Mr. WAXMAN. Our first witness was Dr. Henry Aaron and I asked him whether he thought if we had this kind of insurance reform but didn't require small business to provide insurance, whether this might not increase the amount of money that is paid for private insurance by those who now are covered because they are going to bring in some people that are a little bit more risky and more costly to treat through these insurance reforms.

What do you think about that issue?

Mrs. JOHNSON. I asked that question at a hearing, and—

Mr. WAXMAN. And thereby making some of these employers drop their insurance.

Mrs. JOHNSON. The answer I got back was that 80 percent of the premiums in that small group market would go up. Now, I think the answer was 80 percent if you went to community rating.

I constrain rate variations and so the rates don't go up that much, but they do go up probably 30 to 40 percent. If you eliminate medical underwriting, you eliminate the right of insurance companies to charge a relatively low rate for well people.

But it is that kind of underwriting that has created such a churning in our market put small businesses at such a disadvantage. So I think we should move in this direction. I think by combining what is in my bill with what is in the COSE bill we can restructure the small group market, and encourage the kind of participation that will drive costs down. By mandating that small business educate their employees about the insurance possibilities that are out there, I think two things will happen: First of all, more of those people will stretch themselves to take it, and more small employers will say gee, I can't do the whole thing, but I can do such and such an amount per month.

If we mandate pay or play like in Massachusetts, you are going to have premiums of \$1,600 per year. Not all small businesses can

afford that kind of money; but some small businesses can afford something that would make a material difference to their employees if the policy they are trying to buy is affordable.

Mr. WAXMAN. What do you do to hold down health care costs themselves? Do you have any policies, other than the malpractice tort reform that you are proposing?

Mrs. JOHNSON. There are three ways in which my bill works to hold down health care costs. By increasing access through the small business reform, the community health center reform, and treating self-employed the same as large employers, you reduce cost shifting dramatically. Cost shifting is a cost driver.

Malpractice reform not only should have a real impact on defensive medicine costs, as well as transaction costs, but I also change the tax code to encourage what I call smart buying.

We would no longer provide public subsidies for plans that are benefit rich with no participation. I believe that everybody ought to be part of the purchasing of health care and therefore be sensitive to its costs, although my plan does exempt copayments for well child care and prenatal care. I think there is a place for preventive care to be exempted from a copaid structure. My bill would change the tax code so that a plan would have either copays, a managed care structure, or employer contribution caps. In order to qualify, you could have your choice of any one of those. But we would no longer provide tax benefits to the plans that were developed in the 1960's and that are insensitive to costs.

Mr. WAXMAN. You would have a plan that would be offered that would either be a managed care plan or one where there is a copay requirement for services, and those would be the only ones permitted to be offered to employees—

Mrs. JOHNSON. There is also a safe harbor provision that provides a dollar amount. If your plan met this dollar amount, which is set in the bill at about what it costs now in most plans for family insurance—

Mr. WAXMAN. Do you provide a minimum set of benefits that must be provided in each plan?

Mrs. JOHNSON. Pardon?

Mr. WAXMAN. Do you provide a minimum set of benefits that must be provided in each plan?

Mrs. JOHNSON. No, I don't.

Mr. WAXMAN. So it seems to me that you may be encouraging insurance companies to offer a smaller—a less expensive plan, but also benefits that may be inadequate.

Mrs. JOHNSON. Well, in that particular sector, of course, the State mandates still govern.

Mr. WAXMAN. So you would look to the States to mandate?

Mrs. JOHNSON. Well—using the tax code—the difference that we would make is that we would begin to say to employers you have to look at whether your plan is encouraging people to buy just needed care and appropriate care or any care, and we now insist that you find some way to help differentiate between those two.

It is not a clean line. But we only have the choice of controlling costs by trying to push out of the system inappropriate care. Our only other alternative is to price manage the system. We price manage Medicaid and VA; we are now price managing Medicare.

Frankly, to price manage from Washington is going to be about as effective as price managing from Moscow. It is that simple.

Mr. WAXMAN. You do leave Medicare/Medicaid the way they are?

Mrs. JOHNSON. In this bill I do because I think this is part of that next level of discussion that will create greater system equity and will eventually result in Medicaid being an insurance program based on income and which perhaps deals differently with long term care.

Mr. WAXMAN. Thank you, very much.

Mr. Dannemeyer.

Mr. DANNEMEYER. Can you give us an idea as to whether or not the plan that you are talking about, your plan or the plan you have worked with Rod Chandler, or Grandy's, any one of those three, would they result in any additional cost to the Federal Government?

Mrs. JOHNSON. Probably initially, but I don't think in the long term.

Mr. DANNEMEYER. Can you demonstrate what that would be?

Mrs. JOHNSON. We don't actually have an estimate, but for instance we know that it will cost a fair amount to treat the self-employed person the same as the group employed person, and——

Mr. DANNEMEYER. How would the Federal Government incur this additional cost?

Mrs. JOHNSON. Well, through the subsidies that we would provide for the self-employed person in order to have the same tax benefits that larger employers now enjoy.

Mr. DANNEMEYER. Kind of a tax credit?

Mrs. JOHNSON. Right. On the other hand, we would target the existing tax credits. The problem is that CBO won't talk to us about what that would save.

Mr. DANNEMEYER. You asked the Joint Tax Committee to give you an estimate on what it will cost?

Mrs. JOHNSON. Neither of them will talk about what these things will save.

Mr. DANNEMEYER. Not what they would save, what the additional cost to the Federal Government is from your plan?

Mrs. JOHNSON. We don't have an estimate back yet on that. We have asked for it some months ago.

Mr. DANNEMEYER. How about the additional costs to the State governments from your plan?

Mrs. JOHNSON. There are no additional costs to the State governments from our plan. There should be savings to the State government.

Mr. DANNEMEYER. I understand your concept and I want to commend you for it is that rather than put the burden on the employer in our country to provide insurance, if I understand what you are talking about, you want to have the employee have the responsibility of obtaining insurance himself or herself; is that what you are talking about?

Mrs. JOHNSON. Ultimately. We suggested this in my bill. Ultimately, I would like to say 5 years after the system is in place, the individual would have the responsibility either to have insurance or be registered with a community health clinic.

But until you have these community health centers more established and more broadly based in our society, you can't require the individual to have that responsibility.

Mr. DANNEMEYER. How would you enforce this requirement that an individual have their own insurance?

Mrs. JOHNSON. Well, you know at first I think you want to take as nonpunitive an approach as you can, and perhaps, you simply put a little box on the 1040 that you check saying that I have insurance or I am registered with the community health center.

Mr. DANNEMEYER. What if a person doesn't? What do we do?

Mrs. JOHNSON. Ultimately, if a person doesn't, then when they get sick, they go to the center, they pay the full cost on a sliding scale fee. If they come to the hospital, eventually Medicaid would provide them with a sliding scale fee coverage.

But their income would always be taken into account. So ultimately, if they neglect their health and have to go to a higher cost care, they get referred back to the system but first of all, they pick up their share of the cost. A lot of people would not go to higher cost care if there were really good community health care available, but there aren't.

So ultimately I think we must have the individual take that responsibility, and then see what portion of the population we need to crank down on. But I certainly wouldn't want to mandate that an individual carries insurance when the insurance is not now affordable. The kind of solution that Senator Mitchell offers is that we subsidize the premium so it will be affordable.

Mr. DANNEMEYER. You bypass State mandates in your bill, don't you?

Mrs. JOHNSON. The COSE proposal bypasses State mandates and I in my bill bypass State mandates for the small group market. I think it is really an outrage in America that we allow big businesses to bypass State mandates and not small businesses.

Mr. DANNEMEYER. I agree with you on that.

Mrs. JOHNSON. And furthermore, there is no evidence, even though this has gone on many years, that businesses are choosing an irresponsible small number of benefits. I think that is really important.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Dannemeyer.

Mrs. Johnson, thank you for your testimony. It is an interesting proposal that you have and I look forward to discussing it with you further.

Mr. DANNEMEYER. Mr. Chairman, I have if I may just a few comments here. I have a plan that I have been working on for some time.

I have waited until everyone else has had a chance because I felt that they have had an opportunity to come and share these thoughts with us. This plan I have been working on for about the last year and a half, and I have been able to obtain some figures from the Joint Tax Committee so as to make the claim with credibility that it is neutral, and what it does is place a limitation on the deductibility of health premiums paid by an employer.

And the amount of that deductibility that would be limited would be roughly \$3,695 per family, and a limitation on the fee deductibility for a single employee would be \$1,478.

Now, the limitation on deductibility produces a large amount of revenue. In fact, over 5 years it produces an additional revenue to the Federal Government of \$86.1 billion. It is a lot of money. And then we spend that money in two different ways.

One, to establish a health IRA for individuals who would be eligible to establish a 33 percent credit for up to \$825 in contributions to a medical care savings account. That is to say, if they contributed \$825 to a health IRA, they would have a tax credit of one-third of that, which would be \$275. And from that health IRA they could make expenses for health care costs that are incurred by that person, and for a couple, that amount that they could achieve a credit for and contributions to a health IRA would be \$1,655, so they could take one-third of that, which would be \$550. That would be a credit against their tax.

And then we also would give a tax credit of one-third of the premiums paid on a health policy, and the amount of the credit would vary by age group of the person who bought it. If the person is aged 20 to 29 would have a 33 percent of the tax credit of \$350, one-third of that. Thirty to 39, one-third of \$500 and 40 to 49, \$750. Fifty to 59, one-third of \$1,250, and 60 to 64, one-third of \$1,500. And over 65, one-third of \$2,000.

Now the motivation from this is that it gives an incentive to these people to do that are not currently covered by insurance across this country, the numbers have been stilted to be 30 to 40 to 50 million people, many of whom are working or are in families where people do work.

Now this would give them an incentive to purchase a basic health policy, both from the standpoint of the tax credit on their payment of the premium for the policy, as well as the establishment of a health IRA. And the Joint Taxation Committee has estimated that those who would take advantage of the establishment of a health IRA would consume about \$78 billion over the next 5 years.

And a 33 percent tax credit would consume about \$8.1 billion over the next 5 years. So the money that is saved by limiting the deductibility on premiums paid by large corporations, some \$86.1 billion over 5 years would be spent in these two ways.

So that we would in this plan, it would be revenue neutral. No additional cost to the Federal Government, and given the fact that we are adding four-tenths of \$1 trillion to the national debt this year, I think any plan that comes along that talks about solving the problems of health care in America must address the fact that frankly the Federal Government just doesn't have the additional resources to add on to the existing expenditure stream.

Something has got to give to replace it. But another important feature of this plan is it bypasses State mandates. As I think the gentleman from California is aware, State legislatures around the country have required that any health care policy sold in the State must include coverage for a lot of things that are desirable, but from the standpoint of basic coverage, drive up the cost of the premium.

And as you know, under ERISA, the self-employed can bypass State mandates. And so this plan lets States establish a basic health care policy that would bypass State mandates, and in so doing we have estimated that the cost of the premium for that bare bones or basic coverage would be substantially less than what they have to pay today.

So this is the essence on the plan and I would ask unanimous consent that a summary of this be introduced into the record, and I will be introducing this bill in the House in the next day or so.

Thank you.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Without objection a summary of that proposal will be inserted in the record.

That concludes our hearing for today. We stand adjourned.

[Whereupon, at 12:45 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

[The following material was submitted for the record:]

AFFORDABLE HEALTH INSURANCE ACT OF 1991

Rep. William E. Dannemeyer (R-CA)

Purposes

1. To encourage all employed Americans to purchase basic, no-frills health insurance with coverage for catastrophic illnesses.
2. To encourage individuals who have insurance to expand their coverage or their spouses and dependent children.
3. To permit all Americans to purchase insurance benefits designed to meet their individual and family needs.
4. To create opportunities for the self-employed, the unemployed, and employees of small businesses to purchase insurance on terms now largely restricted to government employees and employees of large businesses.
5. To encourage cost control and prudent decisionmaking through individual self-insurance for small medical expenses and the purchase of health insurance policies with high deductibles and coverage for catastrophic physician and hospital expenses.
6. To create a free market for the purchase of health insurance by removing governmentally-imposed mandates relating to coverage for specific diseases or disabilities, services, health care providers, or mandates relating to maximum or minimum levels of deductibles, coinsurance, or payment rates.
7. To limit the federal government's subsidy of the purchase of private health insurance to the cost of providing no-frills coverage for major medical and catastrophic expenses, whether that coverage is purchased directly by the individual or indirectly through an employer.
8. To enhance the ability of employees who receive health benefits from their employers to choose a package of benefits best suited to their needs and to receive the value of any unwanted benefits in the form of additional salary.

Provisions:

1. Access to No-Frills Health Insurance.

Insurers will be allowed to offer federally qualified health insurance policies to all individuals who desire to purchase such policies.

Policies meeting federal requirements will be exempt from all state-mandated health insurance benefits, including mandates covering specific: (1) diseases and disabilities, (2) medical services, (3) types of health care providers and provider organizations, and (4) maximum or minimum levels of deductibles, coinsurance payments or payment rates. Qualified policies will also be exempt from the payment of state premium taxes, assessments for risk pools, and state rate regulations.

Qualified policies must comply with state laws relating to reserve levels, loss ratios, advertising, marketing, and consumer protection. All other state mandates relating to health insurance are preempted.

2. Tax Equity.

Individuals will receive a 33 percent tax credit for premiums paid on qualified plans up to a limit that varies with the age of the policyholder (see chart below). Married couples shall be entitled to a credit equal to twice the limit available to the older spouse. The 33 percent credit shall be available to taxpayers in the lower tax brackets, as well as to low income taxpayers on a refundable basis. Qualified plans include coverage for families.

Individuals may receive credits for insurance premiums on health insurance policies according to the following schedule:

<u>Age</u>	<u>Credit @ 33% of</u>
20-29	\$ 350
30-39	\$ 500
40-49	\$ 750
50-59	\$1,250
60-64	\$1,500
65-over	\$2,000

The Secretary shall increase or decrease the amount against which the

credit can be taken on an annual basis to reflect changes in the medical care component of the Consumer Price Index.

The credit shall not be available to individuals who are eligible for Medicare benefits during the taxable year, nor shall it be available to individuals who work for employers who offer health insurance on a group basis.

3. Individual Self Insurance.

Individuals are entitled to receive a 33 percent credit for up to \$825 in contributions to a medical care savings account. Married couples can claim the credit (833 percent) for up to \$1,650 in contributions. This amount shall be adjusted by the Secretary on an annual basis to reflect changes in the medical care component of the Consumer Price Index.

The credit shall be available to all taxpayers at the same 33% rate, and shall be refundable for low income citizens. Funds in these accounts accumulate on a tax-free basis and may be used for medical expenses, as defined in the IRS code, without penalty.

In order to qualify for the credit, individuals must leave their contributions in the account for no less than 180 days before withdrawing any portion of it. In addition, individuals with these accounts must maintain a minimum balance of no less than \$250 one year after opening the account, no less than \$500 after the second full year, \$750 after the third full year, and \$1,000 after the fourth full year and thereafter. These accounts may be drawn down without penalty where the individual faces a major medical emergency, as defined by the Secretary.

Only taxpayers who have health insurance are eligible to use these accounts.

4. Employer-Provided Health Benefits

Employers must provide all employees with an estimate of the total annual monetary value of the employee's package of health benefits, along with a description of such benefits.

Health benefits provided by employers, whether on a self-insured basis through ERISA or through an insurer, shall be deductible up to an annual amount of \$3,695 per employee for family coverage, and \$1,478 per employee for individual coverage. These amounts must be adjusted annually to reflect changes in the medical care component of the Consumer Price Index.

5. Group Insurance.

Nothing in the IRS Code shall prohibit or restrict the sale of group insurance through multiple employer pools or trusts, trade groups and other non-profit associations, as well as associations organized by employers.

STATEMENT OF
THE HONORABLE ROBERT T. MATSUI
BEFORE
THE HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
JULY 29, 1991

Mr. Chairman, I want to thank you for the opportunity to appear before the Subcommittee today to discuss legislation I will be introducing to provide universal access to health care for pregnant women and children.

I think we all agree that our future lies in the nation's children. As the policy debate over health care reform evolves, we must acknowledge the importance of ensuring their health and well-being. The investments made today in the health and well-being of American children will pay untold dividends in the future.

Upon Congress' return from the August recess, I plan to introduce a bill that would provide universal access to health care for all pregnant women and children. My bill is modeled after a proposal developed by the American Academy of Pediatrics to begin incrementally to close the gap in access to medical services for pregnant women and children.

My proposal is based on the premise that all pregnant women and children should have access to health care, and that this care must be comprehensive in nature. Regardless of economic or employment status all pregnant women and children would be entitled to health care services.

The United States is the among the wealthiest nations in the world. Yet when it comes to providing health care for our children, we fall far behind our competitors. The U.S. is 21st among industrialized countries in preventing infant deaths. Each year 40,000 babies born in America die before their first birthdays; black babies are twice as likely to die before their first birthday as are their white peers.

Our success as a nation in protecting children against disease is equally dismal. In 1990, some 30 percent of children were not immunized against childhood disease such as measles, mumps, and rubella.

Almost one-quarter of all pregnant women are not insured for maternity care, and an equal percentage do not receive any prenatal care during the first trimester of their pregnancy. Women who don't get regular prenatal care are three times are likely to deliver a low birthweight baby as those who have regular care.

The current health care system fails miserably to meet the needs of children and pregnant women. While Congress debates whom to cover and how best to distribute services, the gap between those who can and cannot secure health care services continues to grow. For a low-income working family, routine pediatric care can cost up to ten percent of their annual income. Nearly 20 percent of all children have not been to the doctor in the past year. While this may not sound significant, minor ailments, such as an ear infection can become severe and permanently disabling if they go undetected and untreated.

We have all heard over and over again the statistics outlining the magnitude of this problem. According to the Congressional Budget Office, there are some 33 million uninsured individuals living in this country. This population is made up of workers, children, families, many of whom are not poor. Children under the age of 18 make up one-quarter of the uninsured population in the U.S. There are some 8.5 million children under the age of 18 and another 6.4 million youths between 18 and 24 years old who lack health insurance coverage.

Most uninsured children have some connection to the work force. Close to two-thirds have at least one parent who works full-time, while another 13 percent have a parent who works part-time. Only 20 percent of uninsured children live in families in which neither their father nor mother is in the work force. Given this connection to the work force, the most logical place to start when developing a plan to cover pregnant women and children is with employers.

Any reforms in the delivery of health insurance coverage must build upon the current system and occur through a partnership between the public and private sectors. The federal government must join together with business to extend insurance coverage to all pregnant women and children. With this in mind, I have drafted my proposal based on the employer "pay or play" model. All employers would be required to provide their workers health insurance coverage for their dependents and for themselves or their spouses when they are pregnant. Employers could do this by either purchasing private health insurance coverage or by paying into a public plan to provide such coverage.

The public plan would provide health insurance coverage on a consistent basis across the country. Pregnant women and children would receive the same comprehensive benefits regardless of whether they receive private insurance through an employer or through the public program.

In recent years Congress has taken steps to increase the numbers of women and children eligible for the Medicaid program. While this has provided a short-term answer to poor women seeking care for themselves and their children, it is not a model on which to base a national plan. Without the development of a comprehensive program to cover all pregnant women and children, regardless of income, we will not begin to reach all those in need of medical care.

As with other universal access plans, my initiative would

institute insurance reforms to ease the difficulty smaller employers now have when purchasing coverage for their workers. Additionally, the measure includes cost containment provisions to address the ever increasing federal investment in health care.

My proposal is not the solution to the health care crisis as a whole, but it does represent a first step toward improving the access that the nation's most vulnerable population has to health care services. The United States must do a better job of meeting the health care needs of its most vulnerable citizens.

The United States must begin to invest in our future. The best bet for that investment is children. Healthy children grow up to be healthy adults, productive adults, and contributors to society. Although the nation is faced with record deficits, money will not be saved by ignoring basic needs such as these. For the dollars invested in prenatal care or childhood immunizations, many more are saved in health care and other societal costs. We are not truly saving money by shortchanging the nation's children.

As Members of Congress, we must work to create a health care umbrella that assures that no child or teenager is left without medical coverage. By doing so, we will make the America of the twenty-first century even healthier and stronger than the America of today.

JIM MOODY
WISCONSIN

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Statement of Representative Jim Moody
Energy and Commerce Health and Environment Subcommittee
July 29, 1991

I would like to thank Chairman Waxman for the opportunity to submit testimony before the Health and Environment Subcommittee today. As all of us here are well aware, serious reform of our health care system is needed. We can no longer afford to patch up the status quo with bandaids.

Our current health care system abounds with economic incentives that drive costs ever upwards, particularly for small and medium sized firms, creates huge cost shifts to business, discourages cost-effective care, and discourages preventative care.

Far too high a proportion of health costs is now rolled into the cost of goods, making U.S. goods less competitive internationally. Health costs are the fastest growing cost component of U.S. goods.

With over 1500 private insurance plans, plus various government programs, the current system is drowning in an avalanche of paperwork, bureaucracy and administrative costs. Each medical visit now generates ten pieces of paper, and doctors' offices spend an average of eighty hours a month processing paperwork.

At least 33 million Americans have no health insurance coverage -- at least no formal insurance. They receive "uncompensated" care, often in emergency rooms when they finally come in "later and sicker" and are much more expensive to treat. This results in massive shifting of costs onto private pay corporate plans, further driving up the costs of goods and further discouraging start-up companies from overing coverage to their workers.

At particular risk under the current system are the 12 million uninsured American children for whom coverage is most urgent on both humanitarian and cost-effective grounds.

Any serious reform must address four issues -- cost, access, benefit scope and financing.

Cost Containment:

1. 12% of our nation's GNP is spent on health care;
2. Health care costs are growing at a compound rate of 12% a year;
3. More than 20% of health care expenditures are spend purely on administration: processing claims, printing forms, paying commissions, etc.

The comparable numbers in Canada are: (1) 8% of GNP, (2) 8.5% compound growth rate and (3) less than 2% for administration. Canadians spend 33% less proportionally, yet cover everyone, and are just as healthy overall.

The most powerful tool for cost containment -- and one which our foreign trading rivals use -- is the market clout of a large rate-setting purchaser. For example, Canada controls costs by establishing tight global budgets for hospitals and uniform doctor fees. These costs do rise with inflation and demographics, but at rates far below the 12% per annum experienced in the U.S.

Access: One key to reducing costs is to provide appropriate treatment at early stages of illness and to stress preventative care. Universal access systems, with low or no deductibles, encourage this. The U.S. is now the only industrialized nation not providing universal access thus contributing to increased total costs.

Benefit Scope: There is a wide "menu" of possible benefits to choose from, but to be cost effective, coverage must include pre- and post-natal care, immunizations and preventive care including check-ups. H.R. 1300 proposes a comprehensive menu, but others are possible.

Financing: Any reform should (1) cut total employer health insurance costs below current levels, (2) not increase the federal deficit, and (3) use a progressive mix of personal, corporate and payroll taxes without significantly increasing burdens to commercial competitiveness.

HR 1300 -- THE UNIVERSAL HEALTH CARE ACT OF 1991

Universal Access -- Every American citizen would be covered, including the 33 million Americans who are now without formal health insurance, including over 550,000 in my home state of Wisconsin. The proposal would be more cost effective than the current system because it would eliminate all cost-shifting, cover preventive care, encourage early treatment and cover all children. It would also increase labor mobility and remove a major reason for staying on welfare.

Single Payer -- A key advantage of a single payer system is to hold down growth in overall costs by applying market purchasing clout vis a vis all health care providers. Administrative costs would be much lower, with only one form for all patients instead of the many forms that now exist. Small firms would be a part of a single nationwide risk pool and thus bear much lower premiums per employee.

Cost Containment -- The U.S. health insurance system must be altered to contain costs. At the current rate, health care would consume 40% of GNP by the year 2030. H.R. 1300 would institute pre-set budgets for hospitals and establish uniform negotiated fees for physicians. Instead of the current system, a hospital or physician would be paid the same basic amount for a given procedure regardless of where it was performed or under what payment system

it fell.

Progressive Financing -- There are many different financing combinations possible. H.R. 1300 would substitute a 6% increase in each company's payroll tax for its current premiums for private health care and workman's compensation -- typically about 12% of payroll. This substitution saves an average of 6% , or \$60,000 for every million dollars of payroll. Small firms, where health care costs run higher than 12% of payroll, would save much more per employee. Firms not currently offering any coverage would pay more -- but not nearly as much as if they offered coverage now.

The balance of H.R. 1300's financing would be through modest enlargement of personal and corporate income taxes, depending on the final benefit menu. In the end, virtually every firm now covering its employees and over 95% of individuals will end up with lower total costs under H.R. 1300.

The plan would be pay-as-you-go and not enlarge the federal deficit. Total U.S. health care costs would be cut by at least \$40 billion as a result of the cost containing and single payer features, yet cover everyone.

I look forward to using this legislation as a point of constructive debate and discussion of how we can reform our health care system.

Again, I appreciate the opportunity to present my testimony to the Health and Environment Subcommittee. I commend their decision to provide a forum for a serious discussion about the wide array of decisions facing us as we move forward in reforming our current health care system.

STATEMENT OF THE HONORABLE EDWARD R. ROYBAL
 CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
 HOUSE SELECT COMMITTEE ON AGING
 BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
 HOUSE ENERGY AND COMMERCE COMMITTEE
 ON
 COMPREHENSIVE PROPOSALS TO EXPAND ACCESS TO HEALTH BENEFITS

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE. I GREATLY APPRECIATE THIS OPPORTUNITY TO APPEAR BEFORE YOU TO DISCUSS WHAT IS ARGUABLY THE MOST IMPORTANT DOMESTIC ISSUE FACING OUR NATION TODAY, HEALTH CARE. TO UNDERSTAND THE PRESSING NEED FOR REFORM, ONE ONLY HAS TO LISTEN TO A FEW REPRESENTATIVE CASES FROM AROUND THE COUNTRY:

o THE CONSEQUENCES OF HAVING NO HEALTH INSURANCE CAN BE DEVASTATING, AS DIANA AND MELVIN SEEGER OF GRAND RAPIDS, MICHIGAN KNOW ALL TOO WELL. MR. SEEGER'S JOB AS A LOGGER DID NOT PROVIDE INSURANCE AND, ALTHOUGH HE EARNED JUST \$9,000 A YEAR, THE COUPLE'S ASSETS MADE THEM INELIGIBLE FOR MEDICAID. MRS. SEEGER COULDN'T AFFORD TO GO TO EITHER OF TWO HOSPITALS WITHIN 20 MINUTES' DRIVE OF THEIR HOME FOR THE DELIVERY OF THEIR THIRD CHILD. INSTEAD, THEY CHOSE A HOSPITAL AN HOUR AND A HALF AWAY. EN ROUTE TO THE HOSPITAL, MRS. SEEGER WENT INTO LABOR. THE SEEGER'S WOUND UP AT AN OUTPATIENT CLINIC UNEQUIPPED TO HANDLE DELIVERIES. THEIR BABY, DAVID, WAS DEPRIVED OF OXYGEN AND LEFT SEVERELY BRAIN DAMAGED. AFTER SPENDING MOST OF HIS FIRST YEAR IN THE HOSPITAL, DAVID WAS RELEASED TO MEDICAL FOSTER CARE. REHOSPITALIZED SEVERAL TIMES FOR SURGERY, DAVID DIED WHEN HE WAS THREE AND A HALF YEARS OLD. "IT'S REALLY TRAGIC," MRS. SEEGER HAS SAID. "HAD WE HAD HEALTH INSURANCE OR BEEN ELIGIBLE FOR MEDICAL ASSISTANCE, WE COULD HAVE GONE TO A CLOSER HOSPITAL, AND DAVID WOULD BE ALIVE TODAY."

o BETTY STEVENS OF CLINTON, MARYLAND, A WIFE AND MOTHER, HAD THE SOLE RESPONSIBILITY OF CARING FOR HER ELDERLY MOTHER AND FATHER, WHO HAD BONE CANCER AND ALZHEIMER'S DISEASE RESPECTIVELY, FOR MORE THAN SEVEN YEARS. HER PARENTS, BOTH IN THEIR 80S, LIVED IN MRS. STEVENS' HOME. AS THE ALZHEIMER'S PROGRESSED, HER FATHER NEEDED CONSTANT SUPERVISION. HE WOULD OFTEN WANDER OUT OF THE HOUSE, SOMETIMES WITHOUT CLOTHING. MRS. STEVENS NURSED HER MOTHER THROUGH SEVERAL COURSES OF CHEMOTHERAPY AND THE ACCOMPANYING NAUSEA, DIARRHEA AND EXHAUSTION. GIVEN THE FAILING HEALTH OF HER PARENTS, BETTY STEVENS PLACED THEM IN A NURSING HOME. AGAINST HER WISHES, SHE HAD TO SELL THE HOME WHERE THEY HAD LIVED FOR 51 YEARS TO COVER THE COST OF THEIR CARE. THE PROCEEDS FROM THE SALE ARE EXPECTED TO RUN OUT IN THE NEAR FUTURE. "SINCE MY DAUGHTER IS AN ONLY CHILD, AND MY GRANDDAUGHTER IS AN ONLY CHILD, THE PATTERN IS ALREADY IN PLACE TO CONTINUE THIS CYCLE OF DISASTER FOR MORE GENERATIONS," BETTY STEVENS HAS SAID. "I DO NOT WANT MY DAUGHTER TO HAVE TO GO THROUGH THE SAME HORRENDOUS SITUATION I AM EXPERIENCING."

TO ADDRESS THESE AND OTHER PROBLEMS IN OUR HEALTH CARE SYSTEM, I WILL THIS WEEK BE REINTRODUCING MY BILL, "USHEALTH," THAT WOULD ENSURE UNIVERSAL ACCESS TO COMPREHENSIVE HEALTH CARE AND LONG-TERM CARE, BOTH IN THE HOME AND IN A NURSING HOME, FOR ALL AMERICANS REGARDLESS OF INCOME, AGE, OR DISABILITY STATUS. MY BILL WOULD PROVIDE HEALTH CARE SECURITY IN THE SAME MANNER THAT SOCIAL SECURITY PROVIDES INCOME SECURITY. EVERYONE WOULD PAY INTO MY HEALTH SECURITY PLAN IN EXCHANGE FOR PROTECTION IN THE EVENT OF RETIREMENT, DISABILITY, OR UNEMPLOYMENT.

WHEN SOCIAL SECURITY WAS FIRST PROPOSED BY PRESIDENT FRANKLIN ROOSEVELT. HE INTENDED TO PROVIDE FOR BOTH INCOME AND

HEALTH CARE SECURITY. IT IS REGRETTABLE THAT WE HAVE NOT FULFILLED HIS VISION OF ENSURING HEALTH CARE FOR ALL AMERICANS. MY BILL SEEKS TO FULFILL THAT DREAM, BUILDING ON THE SUCCESSFUL FRAMEWORK OF SOCIAL SECURITY AND ITS COMPANION PROGRAM, MEDICARE. USHEALTH INCORPORATES MEDICARE AND EXPANDS ELIGIBILITY AND BENEFITS FOR ALL AMERICANS. JUST AS SOCIAL SECURITY ENSURES THAT AMERICANS WILL HAVE ENOUGH INCOME TO LIVE ON WHEN THEY RETIRE OR ARE NO LONGER ABLE TO WORK, "USHEALTH" WOULD ENSURE THAT ALL AMERICANS RECEIVE HEALTH CARE WHEN THEY NEED IT.

EIGHTY-FIVE PERCENT OF WORKING AMERICANS HAVE PRIVATE HEALTH INSURANCE IN CONNECTION WITH THEIR EMPLOYMENT THAT COVERS PRIMARY AND ACUTE CARE. HOWEVER, THIS LEAVES 37 MILLION AMERICANS WITHOUT HEALTH INSURANCE AND MANY MORE WHO ARE UNDERINSURED. IN ADDITION, NEARLY ALL AMERICANS LACK INSURANCE TO COVER THE COSTS OF LONG-TERM CARE IN A NURSING HOME OR AT HOME.

I BELIEVE THAT WE SHOULD BUILD ON WHAT IS IN PLACE BY MAINTAINING THE EMPLOYER'S RESPONSIBILITY TO PROVIDE COVERAGE FOR WORKING PEOPLE AND THEIR DEPENDENTS -- EITHER THROUGH CONTINUING PRIVATE INSURANCE OR PURCHASING USHEALTH.

UNDER MY BILL BOTH EMPLOYER-PROVIDED PRIVATE INSURANCE AND "USHEALTH" WOULD OFFER A FEDERALLY SPECIFIED BENEFIT PACKAGE THAT EXPANDS THE PHYSICIAN AND HOSPITAL BENEFITS THAT MEDICARE PROVIDES AND ADDS PRENATAL CARE, WELL CHILD CARE, PREVENTIVE CARE, AND PRESCRIPTION DRUGS. THOSE NOT WORKING AND THOSE WORKING FOR EMPLOYERS WHO DO NOT PROVIDE PRIVATE HEALTH INSURANCE WOULD BE COVERED BY "USHEALTH".

LONG-TERM CARE IS NOT COVERED BY EMPLOYER PLANS. "USHEALTH" WOULD COVER EVERYONE FOR LONG-TERM CARE, EFFECTIVELY ELIMINATING THE NEED FOR PRIVATE LONG-TERM CARE INSURANCE POLICIES. STUDIES BY MY SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, THE GENERAL ACCOUNTING OFFICE, THE BROOKINGS INSTITUTION, CONSUMER REPORTS, AND OTHERS HAVE DEMONSTRATED THE INABILITY OF PRIVATE INSURANCE TO PROVIDE MEANINGFUL AND AFFORDABLE LONG-TERM CARE PROTECTION NOW OR IN THE FUTURE.

UNDER "USHEALTH," STATES WOULD BE REQUIRED TO MAINTAIN THEIR CURRENT LEVEL OF SPENDING ON HEALTH CARE AND BENEFICIARIES WOULD PAY SOME PREMIUMS, COINSURANCE, AND DEDUCTIBLES. USHEALTH INCLUDES ASSISTANCE FOR THOSE WITH INCOMES BELOW THE POVERTY LEVEL AND PAYMENT ON A SLIDING SCALE FOR THOSE WITH INCOMES BETWEEN 100% AND 200% OF POVERTY. MEDICAID WOULD BE ELIMINATED.

"USHEALTH" COULD BE FINANCED LARGELY BY LIFTING THE CAP ON WAGES SUBJECT TO THE HEALTH INSURANCE AND SOCIAL SECURITY TAXES (ESSENTIALLY TAXING INCOME ABOVE \$53,400). THE ROUGHLY 5% OF AMERICANS EARNING MORE THAN \$53,400 A YEAR WOULD JOIN OTHER WORKERS IN PAYING THE 7.65% PAYROLL TAX ON THEIR FULL INCOME.

IN A NATIONAL SURVEY, POLLSTER LOUIS HARRIS FOUND THAT 70% OF AMERICANS FAVORED LIFTING THE CAP ON INCOME SUBJECT TO THE HEALTH INSURANCE PORTION OF THE PAYROLL TAX TO BROADEN MEDICARE COVERAGE TO INCLUDE LONG-TERM HOME HEALTH CARE. SEVENTY-THREE PERCENT OF AMERICANS EARNING OVER THE CAP, 78% OF BUSINESS EXECUTIVES, AND 61% OF BUSINESS OWNERS SUPPORTED THIS FINANCING. THIS LAYS TO REST THE ARGUMENT THAT THE RICH WHO WOULD PAY THE ADDITIONAL TAXES WOULD NOT SUPPORT SUCH A FINANCING PLAN. WE CAN EXPECT THAT A SIMILAR PERCENTAGE OF AMERICANS WOULD FAVOR LIFTING THE CAP ON WAGES SUBJECT TO THE ENTIRE PAYROLL TAX FOR SUCH A COMPREHENSIVE HEALTH CARE PLAN AS "USHEALTH".

MY PROPOSED FINANCING AND THE ESTIMATED REVENUES THAT WOULD BE RAISED WOULD BE AS FOLLOWS: REMOVE THE CAP ON WAGES SUBJECT TO THE HEALTH INSURANCE TAX (\$5 BILLION); REMOVE THE CAP ON WAGES SUBJECT TO THE SOCIAL SECURITY TAX (\$44 BILLION); AND INCREASE THE HEALTH INSURANCE TAX RATE FROM 1.45% TO 1.8% (\$18 BILLION). THIS WOULD RAISE A TOTAL OF \$67 BILLION.

WE BEGAN ALONG THE PATH OF LIFTING THE CAP ON WAGES SUBJECT TO PAYROLL TAXES IN THE LAST CONGRESS BY LIFTING THE CAP ON WAGES SUBJECT TO THE HEALTH INSURANCE PORTION TO \$125,000 FOR THE PURPOSE OF DEFICIT REDUCTION. NUMEROUS PROPOSALS ARE BEING ADVANCED TO REMOVE THE CAP ON WAGES SUBJECT TO THE ENTIRE PAYROLL TAX FOR OTHER PURPOSES. I BELIEVE IT IS IMPORTANT TO PROPOSE THAT HEALTH CARE FOR ALL AMERICANS SHOULD HAVE FIRST CALL ON THIS SOURCE OF REVENUE. WHAT OTHER ISSUE IS MORE WORTHY OF FUNDING?

I AM DELIGHTED THAT YOU HAVE CALLED THIS HEARING AND I AM CONFIDENT THAT WE CAN WORK TOGETHER TO GAIN PASSAGE OF A COMPREHENSIVE HEALTH CARE PLAN FOR ALL AMERICANS. THANK YOU.

HEALTH CARE REFORM

Controlling Expenditures

THURSDAY, OCTOBER 31, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

This is the third in our series of hearings on health care reform. At our first hearing, we asked witnesses to give us their best predictions about what would happen during the remaining years of this decade if Congress fails to enact health reform legislation.

Their answers gave us a grim picture of the problems we face. Access to care for millions of working Americans and their families will be eroded as employer—especially small employers—are unable to obtain or afford health insurance.

Those outside the workforce face the prospect of shrinking Medicaid programs as States experience recession-driven budget cuts and attempts by the administration to limit their funding options to support health care for the poor.

Both public and private sector health benefit programs will also see health care costs continue their relentless rise. The Congressional Budget Office estimates that, without effective cost containment, health care spending will increase at a rate of 12 to 15 percent each year over the next 5 years.

Clearly, our health financing system is broken and must be fixed. Every day we delay, more Americans go without needed care and the costs of services push insurance coverage beyond the means of more working people and their families. Waiting will not make these problems easier or cheaper to solve.

At our second hearing, we heard from a number of House members who have introduced health care reform proposals on how the system ought to be fixed. Those proposals fall into two broad categories:

Those that would build on existing job-based health benefit protection; and those that would replace the employer-based system with a single payer, public plan.

(221)

I have introduced H.R. 2535, which is based on the recommendations of the Pepper Commission. This bill gives employers a choice: Purchase basic benefits through qualified private plans; or enroll workers and dependents in a public program for a premium set at a fixed percent of payroll.

For Americans outside the workforce—including those eligible for Medicaid—basic benefits would be provided through enrollment in the public plan.

I have chosen this course because we believe we should not disrupt private plans that are providing good health benefit protection. This mixed public/private approach could be the foundation for a movement toward a single payer model once the reforms in our bill are in place.

In fact, through the design of the “pay or play” rules, an employer-based system could be structured so that, over time, more and more Americans would be enrolled in a public plan.

Moreover, many of the efficiencies identified with the single payer model—simplified billing and consolidated claims administration—can also be realized under my bill.

Today’s hearing focuses on a very essential component of any health care reform plan: Cost containment. Everyone recognizes that present increases in spending for health care cannot be sustained, either by private employers, Federal or State governments, or individual consumers.

Further, there is a general agreement that cost controls must be applied to all sectors of the delivery system to be effective. Today’s hearing will concentrate on cost containment in those sectors of the health system that account for the largest expenditures of both public and private funds: Hospitals and physicians.

There is, however, substantially less agreement about what form cost controls should take or what would be an acceptable rate of increase in health expenditures.

In a report earlier this year on rising health care costs, CBO pointed out that fragmented approaches to cost containment in the 1980’s—such as managed care and competition in the private sector and prospective hospital payment and physician price controls under Medicare—“have had little impact on total spending.”

It is my hope that our witnesses today can help us better understand how to slow the rate of increase in health expenditures while we expand access to care and maintain the quality of services.

In the end, I expect that we will need to apply a number of strategies to ensure the affordability and quality of health care. Certainly, some of these policies will require sacrifices in order to improve our health system for all.

I continue to be disappointed that the Bush administration hasn’t joined this debate with constructive proposals of their own. We know they oppose any new Federal funds to expand access to basic benefits. And, we see their cost containment policies are confined to shifting the responsibility for funding Medicare and Medicaid to patients, employers, and the States. These policies do not, in my view, move this debate forward.

What we must all keep in mind is the terrible and unacceptable costs of not acting. I hope that this hearing helps to sustain the

momentum for health care reform and to forge agreement on appropriate and effective cost containment policies.

[The prepared statement of Hon. Mike Synar follows:]

PREPARED STATEMENT OF HON. MIKE SYNAR

Thank you Mr. Chairman.

Today is the third in the Health Subcommittee's most recent series of hearings on health care reform. This past summer's hearings included testimony from the CBO and from over a dozen of our colleagues in Congress supporting various reform proposals.

From the CBO, we learned the good news and bad news about the health care system: The good news is that about 85 percent of Americans have some form of health insurance. The bad news is that about 33 million Americans—this includes about 600,000 Oklahomans—have no health insurance. Because of the escalating costs of health care, many of those with health insurance must struggle with ever higher out of pocket charges—higher premiums, higher deductibles and higher co-payments.

In order to learn more about how the problems of cost, access and quality have affected citizens in my district, I recently held a series of town meetings on health care. I can tell you, Mr. Chairman, this series of meetings had the greatest turnout of any that I have held in my thirteen years in Congress.

Among the problems I heard were: (1) The Sequoyah County farm family that recently dropped its health insurance when the premium rose to \$600 per month and the deductible rose to \$1,000 per year. They will now be among the one-in-five non-elderly Oklahomans without health insurance.

(2) The Okmulgee small businessman whose health insurance costs for his 35 employee firm grew from \$1,274 per month in 1976 to \$7,848 per month this August.

(3) Physicians throughout my district who feel forced to practice costly defensive medicine due to the fear of malpractice suits.

(4) Senior citizens on fixed incomes struggling to pay for costly prescription medicines and increased Medigap premiums—not to mention the confusing paperwork that goes with the Medicare system.

(5) Underfunded Indian health service clinics unable to provide adequate preventive services. I hope to have a remarkable IHS pediatrician testify next month on these problems.

(6) Hospital administrators caught in a web of red tape—the recently proposed Medicaid State matching share rules are a prime example—as they attempt to help provide care for those in need.

Mr. Chairman, I fear that the path to resolution of these problems will be circuitous and rocky. Despite the President's call for a health care reform strategy in his 1990 state of the union address, we learned at the recent Ways and Means hearings that the administration will not be able to present its plan until next summer. The history of Medicare and Medicaid makes it plain that Presidential leadership will be a necessary ingredient to health care reform.

The lack of consensus on which comprehensive reform approach is most desirable is reflected in today's—and earlier—testimony before our subcommittee. This is no doubt a major factor motivating Chairmen Rostenkowski and Bentsen in their recent push for immediate, incremental legislation to reform the dysfunctional small group health insurance market. I especially look forward to Chairman Rostenkowski's thoughts this morning.

Mr. Chairman, my town meetings served to remind me that good health for our families is part of the American dream. In an era of budget deficits that measure the mismatch between our aspirations and available resources, the challenge will be to devise and finance a health care system that promotes quality, affordable care for all Americans.

Mr. WAXMAN. We are going to call our first witness, Lane Kirkland, president of AFL-CIO. Mr. Kirkland has held this position for 12 years, and in this capacity has provided valuable leadership on efforts on behalf of comprehensive health care reform.

The organized labor community has been one of the most forceful advocates of controlling the rate of increase in health care expenditures. The AFL-CIO knows first hand of the large number of labor management disputes involving health care benefits.

The labor community knows only too well these costs are increasingly being financed in the form of lower wages for American workers.

Let me welcome you, Mr. Kirkland, to our hearing this morning, and express my appreciation for your willingness to participate in these hearings. We know of your commitment to more effective health care cost containment. We look forward to your recommendations.

STATEMENT OF LANE KIRKLAND, PRESIDENT, AFL-CIO, ACCOMPANIED BY KAREN IGNAGNI, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT

Mr. KIRKLAND. Thank you, Mr. Chairman. I have with me today Karen Ignagni, the director of our department of employee benefits; and Bob McGlotten, director of our legislative department.

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

We believe that the time is right for Congress to take advantage of the growing consensus for health care reform and to take the lead in fashioning an approach that will reduce health care inflation, expand access, and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does any more damage to American families who have been called upon to absorb a major share of cost increases.

American businesses are attempting to do their fair share by providing health care coverage, and health care consumers who are frustrated with insurance underwriting practices and the paperwork burdens associated with the current system.

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the Nation's health care crisis.

When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their real right to strike.

A recent study by the AFL-CIO found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care.

Last year, a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980's, the health care crisis further exacerbated the economic decline of the middle class. In the 10 year period from 1980 to 1990, real wages have gone down while the percent of family income going toward health care increased.

If these trends continue it will threaten the ability of working Americans to maintain their homes, educate their children, and achieve income security and retirement.

A similar trend is occurring naturally as health care consumes a growing share of our economic resources. In short, we are paying more for less.

The Nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada; 90 percent more than Germany; and 125 percent more than Japan.

Rather than become mired in esoteric debates about competition versus regulation, the committee and the Congress should recognize that the most costly solution would be to do nothing at all.

Last fall the AFL-CIO commissioned a study to determine how much could be saved if Congress established a single cost containment program for all payers.

It was estimated that just a 2-percent reduction in the projected rate of growth and health inflation will save \$165 billion by the end of the decade.

In short, our health care problems are urgent, and they are being exacerbated by a delay in acting on them.

The labor movement is united in its pursuit of fundamental restructuring of the system. And we have three essential goals:

To contain health care inflation; to provide all Americans access to health care; and to improve the quality of care.

All of the unions within the AFL-CIO support these goals. Some of our affiliates support the implementation as soon as possible of a single payer approach. All of our unions believe we need congressional action now.

The AFL-CIO is encouraged by the sheer number of bills that have been introduced to reform the health care system and the commitment on the part of members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL-CIO has long advocated enactment of a social insurance, national insurance health plan. H.R. 650 introduced by Representative Stark; H.R. 1300 introduced by Representative Russo, and H.R. 8 introduced by Representative Oaker, all call for restructuring the present system so that there is a single payer for doctor's bills and hospital charges.

Labor is united in its belief that a single payer approach would be the best mechanism for this restructuring. We are also united in the belief the urgency of the crisis requires us to seek relief now, without compromising the principles described earlier in this testimony and to support measures that can be enacted.

We commend you, Mr. Chairman, for the introduction of H.R. 2535, designed to solve the problems of rising costs and declining access to care. We strongly support your concept of using the Medicare payment methodology as a means to contain doctor's fees and hospital charges.

However, nothing short of a mandatory cost containment system will be effective in bringing costs under control and eliminating cost shifting, which has had such a severe effect on collective bargaining.

On the administrative side, we strongly support your proposal to do away with the gaps in coverage for those who do not receive protection through their place of employment.

We also commend you for proposing that early periodic screening and detection services for children be an essential part of the Federal minimum benefits to which all Americans are entitled.

H.R. 3205 introduced by Representative Rostenkowski includes an effective national cost containment strategy to bring health care inflation under control by placing a mandatory cap on the rate of increase in health care expenditures.

Like your legislation, it would level the playing field among employers by requiring all of them to contribute to the cost of basic health coverage, and it would streamline the patch work quilt of Federal and State programs.

By reducing the age of eligibility for Medicare, the bill would solve the retiree health crisis.

I testified before the Ways and Means Committee last week. While we support the effort to make the system progressive by avoiding financing alternatives that would be less equitable across the income spectrum, we will be working with the committee to reduce the burden on working families.

I also would like to comment on H.R. 3626, the new legislation introduced last week by Congressman Rostenkowski.

The AFL-CIO has been on record in opposing a reform strategy bill exclusively on small market insurance reform. While we are encouraged by the bill's attempt also to put the issues of cost containment, a Federal core benefit package, and a national commission on the table, we believe that the current provisions do not go far enough to address the crisis that we face.

As in your legislation extending the Medicare cost containment methodology to all payers, as well as prohibiting physicians from charging over established rates, would go a long way to reducing the pressure of health care inflation, but it would not address issues such as voluntary or inappropriate practices as effectively as a mandatory system with a broad expenditure target.

Requiring Medicare serve as the core benefit package to be offered by all insurers in the small group market would be a positive step toward the development of a core benefit package to which all Americans are entitled.

However, we hope that Congress will move expeditiously to require that all business contribute to the cost of health care for their employees and their dependents and eliminate the competitive advantage that now exists for firms that refuse to provide health care coverage.

Ultimately, our assessment on H.R. 3626 as it moves through committee and changes are made, will depend on whether it is the first step in a broad strategic plan to address the health care crisis or the only step toward reform.

In sum the AFL-CIO believes that Congress now has before it all of the essential elements for comprehensive health care reform legislation.

Mr. Chairman, there is real suffering going on out there. Nothing short of full-scale reform will solve our problems. We urge this committee and the Congress to put together a legislative package that blends the best of the alternative plans that have been offered and to move national health care reform in this Congress.

In this regard we urge you to consider the approach embodied in S. 1669, introduced by Senators Simon and Adams, which gives States the option to develop a single payer system within the context of an enforceable all-payers cost containment system.

Those who advocate a single payer system and those who advocate a limited payer system must work together for the ultimate goal of reform. The people deserve it, the crisis demands it, and our ability to be competitive in the 21st century will depend upon it.

Thank you, Mr. Chairman.

[Testimony resumes on p. 239.]

[The prepared statement of Mr. Kirkland follows:]

TESTIMONY OF LANE KIRKLAND, PRESIDENT
AMERICAN FEDERATION OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
ON HEALTH CARE REFORM

91-51

October 31, 1991

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. In this effort, we are now being joined by organized medicine and many in the business community who are offering their proposals for national health reform. This represents true progress toward resolution of the nation's health care crisis.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning an approach that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does further damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care consumers who are frustrated with insurance underwriting practices and the paperwork burdens associated with the current system.

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management

disputes have been caused by the nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL-CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. The average hourly wage, adjusted for inflation, dropped from \$10.56 in 1980 to \$10.03 in 1990. During the same period, health costs for households increased from six percent to nine percent of gross earnings.

Health care costs are depleting the family income necessary for working Americans to maintain their homes, educate their children and achieve income security in retirement. If current trends continue, by the year 2000 one third of total compensation will go to pay for health care at the expense of wages and other benefit improvements.

A similar trend is occurring nationally, as health care consumes a growing share of our economic resources. In 1980, health care programs accounted for 17 percent of domestic spending. Now that figure is 22 percent and by the middle of the decade, it will be 30 percent. Health care inflation is needlessly siphoning off valuable economic resources necessary for other national priorities, including education, infrastructure and research and

development.

While public expenditures grow, beneficiaries of public programs continue to lose ground. Senior citizens pay more for health care than they did prior to passage of Medicare and 60 percent of those with incomes below the federal poverty level do not qualify for Medicaid.

In short, we are paying more for less. A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan. Rather than become mired in esoteric debates about competition vs. regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

Last Fall, the AFL-CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers. They estimated that just a two percent reduction in the projected rate of growth in health inflation will save \$165 billion (in 1990 dollars) by the end of the decade.

As part of its deliberative process, we would urge the Committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. While these systems have unique structures and differ on numbers of payers, all of these countries have achieved universal access to health care benefits and effectively controlled costs by setting budget targets and paying providers uniform rates.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who

oppose reform. Taken together, the health care systems throughout the industrial world provide conclusive evidence that it is possible to provide coverage to all Americans far more effectively and at an affordable cost.

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to both consumers and providers who are frustrated with red tape and paperwork. Even those who support the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U. S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. While we do have more technology than other industrial countries, it is virtually impossible to defend the high rates of surgery and diagnostic tests,

the relatively small attention paid to preventive care, including the immunization of our children, the lack of coordinated technology assessment and the duplication of equipment in our current system.

In short, our health care problems are urgent -- and they are being exacerbated by our delay in acting on them.

The labor movement is united in its pursuit of fundamental restructuring of the system and we have three essential goals: to contain health care inflation; to provide all Americans access to care; and to improve the quality of services.

All of the unions within the AFL-CIO support these goals. Some of our affiliates support the implementation as soon as possible of a single payer approach. But all of the unions believe that we need Congressional action now to address the health care crisis, and they support the Federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

Let me take this opportunity to discuss our fundamental principles and our proposals to achieve these goals.

1. Contain the Growth in Health Care Costs

We can not hope to expand access or improve quality without controlling health care costs. The Federation proposes a comprehensive strategy to bring health care costs under control. To achieve this objective, we urge Congress to establish a national commission composed of consumers, labor, management, government and providers to administer a single national cost containment program. The primary functions of such a commission would be to establish a limit on the rate of growth

in health expenditures nationally and by state; to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets; and to establish controls on capital costs consistent with the overall national expenditure targets. Once the rates are negotiated, they would apply to all payers, including government programs, to prevent cost-shifting.

Payments to physicians should be on the basis of a resource based relative value schedule, with geographic adjustments as necessary. Payment rates to hospitals should be on a DRG basis, with adjustments for facilities with special needs.

We believe it is time to overhaul our costly administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, develop a uniform health care information system and simplify paperwork.

Recently, there has been a growing interest in reforming insurance practices in the small group market where premiums are unaffordable. While we support such long-overdue reforms, the AFL-CIO believes that reforms should be developed by Congress -- not the states -- to assure uniformity across the country. Specifically, we believe regulation is warranted to put a stop to current insurance practices that keep individuals and employers out of the health system or force them to pay contributions that are disproportionately high.

2. Provide Universal Access

Health care should be a right of all Americans. To achieve this objective, we urge Congress to establish a core benefit package to which all Americans are

entitled, notwithstanding employment history, health status or state of residence. In our view, all employers, including the federal government, should be required to contribute fairly to the cost of care for workers and their families. Congress should put an end to the patchwork quilt of federal and state health care programs and establish one federal program that would cover the unemployed, those currently receiving protection through state Medicaid programs, and workers not covered through their employers.

The issue of retiree health care has become one of the most difficult at the bargaining table as a result of the new accounting regulations put forth by the Financial Accounting Standards Board (FASB) scheduled to go into effect in 1993. The FASB rules would require companies -- for the first time -- to list on their Balance Sheets estimates of liabilities for providing health care benefits to current and future retirees. The new regulations have caused a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions have already seriously increased the number of retirees without coverage and the problem is growing.

Access to health care for early retirees not covered by employer plans is severely limited by pre-existing condition exclusions and the excessive administrative cost of individual policies.

We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age. Specifically, we propose bringing the Medicare age down to 60. This would spread

the cost of retiree health care over the entire population and no longer disproportionately penalize employers who have attempted to protect their retirees against the high cost of getting sick.

3. Improve Quality of Care

The Federation proposes that the U.S. make a major commitment to improving the quality of care -- including development of practice guidelines for physicians, research to determine which procedures and technology are effective and a national strategy to reform the current system of handling malpractice disputes.

We believe serious efforts must be made to use the skills and talents of a variety of health care providers, including nurses and other professionals, in a wide variety of delivery settings, including institutions, community-based treatment, home care, schools and places of employment.

PENDING LEGISLATION

The AFL-CIO is encouraged by the sheer numbers of bills that have been introduced to reform the health care system and the commitment on the part of Members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL-CIO has long advocated enactment of a social insurance national health insurance plan. H.R. 650, introduced by Representative Stark, H.R. 1300 introduced by Representative Russo, and H.R. 8 introduced by Representative Oakar all call for restructuring the present system so that there is a single payer for doctors' bills and hospital charges.

Labor is united in its belief that a single payer approach would be the best mechanism for this restructuring. We also are united in our belief that the urgency of the crisis requires us to seek relief now, without compromising the principles described earlier in this testimony, and to support measures that can be enacted.

We commend you, Mr. Chairman, for the introduction of H.R. 2535 designed to solve the problems of rising costs and declining access to care. We strongly support your concept of using the Medicare payment methodology as a means to contain doctors fees and hospital charges; however, nothing short of a mandatory cost containment system will be effective in bringing costs under control and in eliminating cost shifting, which has had such a severe effect on collective bargaining. On the administrative side, we strongly support your proposal to do away with the gaps in coverage for those who do not receive protection through their place of employment. We also commend you for proposing that early periodic screening and detection services for children be an essential part of the federal minimum benefits to which all Americans are entitled.

H. R. 3205, introduced by Representative Rostenkowski, includes an effective national cost containment strategy to bring health care inflation under control, by placing a mandatory cap on the rate of increase in health care expenditures. Like your legislation, it would level the playing field among employers by requiring all of them to contribute to the cost of basic health coverage and it would streamline the patchwork quilt of federal and state programs. By reducing the age of eligibility for Medicare, the bill would solve the retiree health crisis.

I testified before the Ways and Means Committee last week. While we support the effort to make the system progressive by avoiding financing alternatives that would be less equitable across the income spectrum, we will be working with the Committee to reduce the burden on working families.

I also would like to comment on H.R. 3626, the new legislation introduced last week by Congressman Rostenkowski. The AFL-CIO has been on record in opposing a reform strategy build exclusively on small market insurance reform. While we are encouraged by the bill's attempt also to put the issues of cost containment, a federal core benefit package and a national commission on the table, we believe that the current provisions do not go far enough to address the crisis that we face.

As in your legislation, extending the Medicare cost containment methodology to all payers, as well as prohibiting physicians from charging over established rates, would go a long way to reducing the pressure of health care inflation, but it would not address issues, such as volume or inappropriate practice, as effectively as a broad expenditure target. Unless we develop a uniform national cost containment system that is mandatory for all payers, we will not solve the problem of cost-shifting.

Requiring that Medicare serve as the core benefit package to be offered by all insurers in the small group market would be a positive step toward the development of a core benefit package to which all Americans are entitled; however, we hope that Congress will move expeditiously to require that all businesses contribute to the cost of health care for their employees and their dependents and eliminate the competitive advantage that now exists for firms that refuse to provide health care coverage.

Ultimately, our assessment on H.R. 3626, as it moves through Committee and changes are made, will depend on whether it is the first step in a broad strategic plan to address the health care crisis or the only step toward reform.

On the Senate side, we are delighted with the introduction of S. 1227 by Senator Mitchell and other key Democrats and with S. 1669, introduced by Senators Simon and Adams, amending the leadership bill to strengthen the cost containment provisions by making it a mandatory system and dropping the Medicare age to 60. The Simon-Adams legislation also contains a unique feature to bring together supporters of single payer and limited payer approaches. The legislation allows each state, within specific state budget targets, to determine how it desires to establish its cost containment system, including the option to adopt single payer.

S. 1177, introduced by Senator Rockefeller, and the companion bill to your proposal also has contributed to the discussion in the Senate of this issue. S. 1446, introduced by Senator Kerrey offers yet another important contribution to the debate.

CONCLUSION

In sum, the AFL-CIO believes that Congress now has before it all of the essential elements for comprehensive health care reform legislation.

Mr. Chairman, there is real suffering going on out there. Nothing short of full scale reform will solve our problems. We urge this Committee and the Congress to put together a legislative package that blends the best of the alternative plans that have been offered and to move national health care reform in this Congress. In this regard, we urge you to consider the approach embodied in S. 1669, which gives states the option to develop a single payer system within the context of an enforceable all payers cost containment system.

Those who advocate a single payer system and those who advocate a limited payer system must work together for the ultimate goal of reform. The people deserve it, the crisis demands it and our ability to be competitive in the 21st century will depend upon it.

Mr. WAXMAN. Mr. Kirkland, when we finally enact health care reform in this country we look back over the decades of struggle to get to that point. I think there is no group that is going to be singled out for greater praise than the AFL-CIO. Its championing this cause, both to cover people who are left without and to bring controls to those fortunate enough to have insurance and not to be pushed out of the market to keep that insurance.

And I think not only will the AFL-CIO deserve an enormous amount of the credit, but you personally have brought your dedication, commitment and energy behind reminding us we can't just continue to push this issue aside.

I regret the fact that so many of our members are tied up on the Floor. The banking bill is in markup at another committee. I would have liked all of them to have heard you today. I am pleased you are here, because we will share your testimony with them.

It is essential, it seems to me, for us to finally come to terms with this problem and deal with the two outstanding problems:

Making sure every American has access to care as a matter of right, not just those who can afford it, not for just those who have the good fortune to have a union to bargain for them.

The second part is to contain these costs. We are looking now at an incredible amount of costs, but this shouldn't be a surprise. This is something we have known about for some time.

In the late seventies, the Carter administration said let's try to do something about the hospital costs. Let's try to contain those costs; and we saw the rejection of that approach with the notion that either voluntary actions would be successful or some competition in the economy and the health sector would produce the results.

Well, they are wrong. At some point, people have to recognize that a lot of the so-called experts have been wrong, but one group has been right, and that has been organized labor.

As to the approach of cost containment itself, you have spoken here today forcefully for the idea of mandatory limits on health expenditures and uniform rates for all payers.

We are going to hear later from other witnesses who will raise the specter that if we followed that approach that what we are going to have is declining quality, rationing, budget-driven expenditure targets, and they are going to come up with other ways to approach the problem of cost containment.

I don't know if you have had a chance to look at some of their ideas, but how do you react to that charge, and how do you respond to some of the suggestions that we shouldn't go this far in the cost containment area?

Mr. KIRKLAND. The first form of rationing is the system today. We want to cure that. We want to cure it on an approach that gives equal access to all Americans. It is being rationed today, and the experiments that have been touted and practiced under the existing nonmanaged/managed care, other cost controls, reviews of hospital stays by insurance administrators, certainly involve an injection of administrative and cost considerations in the medical decisions under the existing system, I think to a far greater degree than the mandatory cost control system that we describe would.

I think we ought to go directly to what is bound to be the ultimate unnecessary cost review system, under a national plan of health care reform. I believe that was the experience under Medicare.

I believe the cost control mechanism under Medicare was originally set up on a nonmandatory basis, and experience and the harsh facts. Let it not be because somebody wanted to do it, that becoming mandatory it has to be. It ultimately will have to be. You might as well do it now and do it right.

Mr. WAXMAN. Some of our allies in the argument for national health insurance, I think, take an approach that I feel a little uncomfortable with, and that is the argument that I have heard advanced, we can cover everybody for everything, and there is not going to be an extra cost involved to do that, and there won't be any decrease in what everybody now has.

The reason I feel uncomfortable with it, I don't think it is an honest statement. If we bring in the 34 million-plus people who don't have insurance and cover them, we are going to have to put some controls on that system.

As we put controls on the system and require budgeting, some decisions are going to have to be made that some things will have to wait while other services have to be dealt with immediately.

Now, I feel uncomfortable with people saying nobody will have to wait for anything and no one will have to pay for anything.

Don't you accept the fact that we ought to tell the American people that they are going to have a much better system when all is said and done, but that there are going to be some tradeoffs, and we should be honest about it?

Mr. KIRKLAND. I certainly agree with that, sir. I think the question will be not the fact that it is going to cost—there are going to be costs involved and they have to be met, but it is our firm conviction they should be met on a social insurance basis, on a basis that spreads those costs equitably, and that the necessary funds should be raised in a fair and equitable manner.

We recognize the things that we want and that we think the people of this country and our members and other workers desperately need are not free, and I believe we have a fairly proud record, unlike many others who believe that somehow it will come out of the air like the voodoo economics that has been in vogue in the past, that cutting taxes will increase revenues, et cetera.

We believe if we are seeking a value, we should be willing to pay the cost, and I think we have a pretty good record of showing our members are prepared to bear their fair share of those costs. They are bearing them now in an inequitable and unfair and oppressive way.

If those costs can be translated into a system based upon social insurance principles, the country will be well served.

As I have said before, in all of the problems that face this country and face people and families, if you can identify problems that can be translated effectively into concrete costs, and devise a system whereby those costs are equitably provided for in advance under the social insurance system, then we are fortunate.

There are not many of the problems this country faces that can be so defined and so translated and so met. This is one of them, just as old age retirement was one of them.

The alternatives are ruinous for human beings, just as the absence of a social insurance system for the elderly when they can no longer work is ruinous. Those alternatives were not idealistic, but of importance, at any rate, of old folks being sheltered in the bosom of a family, but the county poorhouse and enormous burdens on young and old alike.

We solved that problem to a very great extent by the social insurance mechanism of old age and survivors insurance for the benefit of young, old, and middle-aged alike.

We can do the same with the health care crisis, and it is irresponsible and profligate not to do it, to allow this situation to continue, and amount, and become ever more oppressive before it overwhelms us.

We have 12 percent or so of our Gross National Product being spent on health care now, more than any other industrial country, and it is mounting rapidly. I wouldn't particularly object to 12 percent of our Gross National Product being dedicated to health.

The problem is today, what we are getting for it is a ruinous system. Some people are getting great medical care, some are getting none. Everyone except the privileged few faces the potential of disaster if they become so unfortunate as to have a health care crisis.

If that 12 percent could be translated into a system that A, incorporates restraints, prudent and well-administered restraints on the total costs of medical care, assures quality and provides access to all, then that is money well spent and well worth the price.

Mr. WAXMAN. Thank you very much.

Mr. Sikorski.

Mr. SIKORSKI. Thank you, Mr. Chairman, to all of you.

I just wanted to echo the chairman's words. My dad was 42 to 43 years a laborer for the railroad, AFL-CIO, and even though working fulltime in a part-time and a part-time job, and my mother working most of that time, I qualified for the free and reduced school lunch program and when I went to college, they called it economic opportunity grants then based on just income.

We had health care through that period because of the contracts that were negotiated by labor for and with him. But beyond that, looking at this issue, I think 90-some percent of your members are already covered, and when you are here talking about access, you are continuing a tradition of the AFL-CIO of working, whether it is veterans' benefits after World War II, or Social Security, or equal rights for women or civil rights, or a space program in NASA, or interstate highway bill, on and on.

And I just want to point that out to people, and compliment you for coming here and raising issues and the conscience of the Congress, issues that affect your members but go beyond it as well.

I want to compliment you.

Mr. KIRKLAND. We don't believe that the well-being of our members and their families can be assured in a jungle where other people are suffering. We think we are part of the whole and we have a responsibility for the whole.

I do not think we can advance the—long advance the objectives and goals of great union members unless the country moves ahead and people are generally well-served by their government.

Mr. SIKORSKI. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. Mr. Kirkland, let me commend you and the AFL-CIO. I have talked often with Ms. Ignagni and Mr. McGlotten. I think we all know medical costs are gobbling up everything in sight.

There are no costs rising like medical costs in this country, and I have come to the conclusion that because of our fast growing elderly population, and because of this explosion of technology that almost has us moving towards immortality, that we can continue down this road.

And even if we spent virtually our whole Gross National Product on medical care, we still wouldn't be covering anybody unless we made some changes.

My question is, do you think it is time that we came together as citizens and developed a process for choosing what our priorities ought to be in health care, and make the judgment that it is going to be very, very tough to do everything immediately, but that we ought to come together as citizens and make some judgments about what our priorities ought to be?

Mr. KIRKLAND. Well, of course. We do it in a way anyway. Inaction is a decision, just as action is. Unfortunately, it has been the wrong decision.

I do not think that there is any significant body of opinion in this country and any community, whether it is the community that we represent or the community represented by doctors, hospitals, providers, or the community of employers, with some exceptions, meaning primarily they escaped their share and offloaded their burden onto others and therefore are defending an unwarranted preferred position.

I wouldn't today agree that this is under anybody's scale of what is important, a matter of the most urgent concern. I think it is incumbent upon the Congress to reflect that, to act upon it.

Mr. WYDEN. Let me follow it up with you Ms. Ignagni. We have something like 10 major bills for health care on the table right now. I am convinced that as we look at this issue, we don't have a system for deciding what the priorities ought to be in our health care system, and even how it was determined that those bills would cover one particular program or another.

Do you think it would make sense, as we start this national debate, that we develop a process in this country for really making some judgments; for example, that care for kids ought to come first and preventive care ought to be at the top of the list, and something else would come third or fifth, and develop that kind of process?

Because my sense is with the aging population, the technology, we could spend everything on medical care, and we might not have hit the priorities like prevention and kids and some of the things that I know the association has worked for.

Ms. IGNAGNI. As you know, Congressman, we have thought long and hard about the infrastructure here that will be necessary to move in the direction that we have proposed.

What President Kirkland has set out is a strategic plan from getting from A to B. Inherent in that is the principle we set up a structure to administer the system that is fair and equitable.

In our view, the only way to do that is set up a commission-like structure where all the parties who are concerned with this problem—every party in America would be represented around that table.

Government would have a seat at the table and they would do some real negotiating of the type that goes on in various sectors today to establish priorities, to determine these issues that you are getting to.

It is not enough today to say simply we have to furnish medically necessary benefits. We have to figure out a way to define that.

On the other hand, we need to do that for every man and woman and child in the United States, as opposed to focusing on only one particular constituency group.

Mr. WYDEN. I very much share that view. I just wanted to understand clearly then, you envisioned this commission, the AFL-CIO advocates as being the forum for national debate of what our national health care priorities are making some judgments through that commission, how we would make sure everybody had access to a basic package of benefits.

Mr. KIRKLAND. Not entirely, sir, no. The legislation must incorporate the issue of access and not wait for a commission to decide it. The role of the commission is to address the question of the allocation of available resources and their costs, while assuring those resources are available to fulfill the goal of full access.

We propose that the—there is one issue of priority that is incorporated in the idea that there should be a core of benefits patterned after Medicare. That is a priority decision, but it is a core of benefits that should be available to everyone.

Not this group, that group or the other group, but everyone.

Mr. WYDEN. Would you favor then extending the core set of Medicare benefits to everybody who is uninsured right now?

Mr. KIRKLAND. Yes.

Mr. WYDEN. Okay. I think your commission idea—

Mr. KIRKLAND. If we don't do that, it is not worth while.

Mr. WYDEN. I think your commission idea is a very sensible one, in terms of providing a forum for people to discuss these issues, but I would hope that as we get into it, we look at more than having this commission follow up on what a legislative body does in terms of cost allocation and these kinds of issues.

I think what is really holding this country back is that we are saying we want to do everything because we feel strongly about our people. We don't have the revenue to do it all, and then we don't have a process about making judgments about what is important, and we have, as you correctly said, Mr. Kirkland, we have got rationing right now. We have got rationing that goes on over all this country.

It is made by lopping people off the government roll or cut back off your people in the private sector. I hope through your commis-

sion, and other sensible ideas, that we can come up with a different process for deciding what our priorities are.

My sense is we can't really get into this cost containment issue unless we do it. I commend the association for your good work.

Mr. KIRKLAND. I just want to reemphasize the points—I don't believe you are suggesting that, but if there is any thought that a commission alone solves the problem, that is not what we are saying.

Nor are we saying such a commission is the forum for resolving these other objectives or a condition precedent to them. That is, if that is the approach anybody wants to take, simply setting up a commission, goodbye Charlie.

We have been through that many times before. I regard that as a classic form of inaction. There are three forms of serious inaction. One is a commission and another is a committee, and the third is a pilot project.

Mr. WYDEN. Let me tell you, I come from a State who has the only commission on health in the country that got together and made some tough choices, and the AFL-CIO backed it all the way.

The AFL-CIO was there with the consumer groups, the business groups, and people said we are going to say this comes first. We are going to say this comes third, this comes ninth. This comes 700th.

I think that kind of model or something like it is going to be a part of this national health debate, or else we are not going to be able to contain costs and achieve the AFL-CIO's goal.

So we have some commissions out there, and you all in Oregon have backed it strongly, and I think give us a model.

I thank you for the time, Mr. Chairman.

Mr. KIRKLAND. On the issue of immediate and early resolution of the issue of access, I am willing for this committee and other committees of the Congress to be the commission and do it.

Mr. WAXMAN. Thank you Mr. Wyden.

Mr. Kostmayer.

Mr. KOSTMAYER. Thank you.

Mr. Kirkland, not too long ago our subcommittee heard testimony from GAO and heard the amount of money they spent on paper shuffling in this country is about 23 percent of total health care, or about \$130 billion.

Do you think those figures are accurate? If you think they are accurate, doesn't that mean if we have a system that doesn't waste this amount of money, we could spend that money instead on health care, which might reduce the necessity for increasing taxes or for spending more on the program?

Mr. KIRKLAND. I am not a certified public accountant, sir, and I cannot vouch for the dollar by dollar accuracy of those figures, but it certainly is in keeping with commonsense observations and experience.

Mr. KOSTMAYER. I don't have any further questions. I want to commend you for the leadership role you have taken and the leadership role organized labor has taken. I represent a congressional district where we have unfortunately very few union members.

This is an issue important to all Americans. We are having an election in a few days in Pennsylvania, to fill a Senate seat, and it

looks like this issue may well determine the outcome of that election in Pennsylvania.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kostmayer.

Mr. Kirkland, when you talk about a commission, as I understand your idea of a commission, that is to make the allocations of dollars, but as I also understand what you are suggesting, there ought to be a minimum set of benefits that everyone will have.

You are not suggesting that commission will decide what benefits we will have, and some people will be told, you might have had hospitalization last week, but this week, we just don't have the funds for it.

Mr. KIRKLAND. You are correct, sir.

Mr. WAXMAN. What do you think this idea of a commission to start rationing, based on services for some people?

Mr. KIRKLAND. That is not what we would advocate, favor or support.

Mr. WAXMAN. You would suggest a minimum set of benefits.

Mr. KIRKLAND. Yes.

Mr. WAXMAN. People who could afford to do more on their own, that is their business, but at least every American should be guaranteed a minimum access to care.

Mr. KIRKLAND. That is correct, sir, for openers.

Mr. WYDEN. Mr. Chairman, may I ask one additional question?

Mr. WAXMAN. Yes, Mr. Wyden.

Mr. WYDEN. I very much favor Americans getting access to that minimum set of benefits. How do we decide what that set of benefits ought to be, so as to use our dollars the best way?

Mr. KIRKLAND. I don't think that is terribly complicated, sir. We have a pattern in Medicare. We have a pattern in Medicaid, which is a core set of benefits, and we start from there.

Mr. WYDEN. Well, I just would hope we could learn some of the lessons. When you look at Medicaid, for example, Medicaid has gotten clobbered by the drug companies. Drug companies have basically stiffed the Medicaid program.

Now, we need something that will more aggressively control the costs.

Mr. KIRKLAND. That is not the fault of the Medicaid program, sir. The question is the abuse of drug costs by the pharmaceutical companies is an issue that needs to be addressed. You can't attribute that as being caused by Medicaid or Medicare.

Mr. WYDEN. We are in agreement on that. It would seem to me for the association and people like Mr. Waxman and myself who want to see a flat plan, very much a vision of labor, we are going to have to break with that Medicaid model and have some tough controls on the drug companies in order to insure we get our money's worth.

We haven't had that with Medicaid, and I just hope that we look at some different kind of thinking as we go to this national model, rather than just say, let's repeat Medicaid and Medicare.

Despite the phenomenal work done by the chairman of this committee, Mr. Waxman, on Medicaid, we have more poor people falling between the cracks every year. I think it is those kinds of things we got to respond to.

You all have done excellent work and I have had many conversations with Ms. Ignagni about these issues.

Mr. WAXMAN. We thank you very much.

We had hoped to have Mr. Rostenkowski. He is working on negotiations of the unemployment benefits bill. He would like us to acknowledge his regrets, and asks that his statement be part of the record. Without objection, that will be the order.

[The prepared statement of Mr. Rostenkowski follows:]

STATEMENT OF
 DAN ROSTENKOWSKI, CHAIRMAN
 COMMITTEE ON WAYS AND MEANS
 AT A HEARING ON HEALTH CARE REFORM
 OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
 COMMITTEE ON ENERGY AND COMMERCE

OCTOBER 31, 1991

Chairman Waxman and Members of the Subcommittee. It is a pleasure to appear before you this morning to talk about a problem that should embarrass us all: the United States of America -- despite our great wealth, technological innovation and ability -- is today unable to assure all of its citizens that their basic health care needs will be met.

The Committee on Ways and Means has spent the better part of this year learning about the significant problems of our nation's health system. We've held a Committee retreat on the subject, convened a series of hearings on long-term health strategies, and caucused among ourselves. A number of my colleagues -- both on and off the Committee -- have introduced health care reform proposals and the Committee has already devoted six days of hearings to reviewing these proposals. You are to be commended for beginning that same process here in the Energy and Commerce Committee. If we are going to solve this problem, we must begin by educating ourselves and the American people.

Approximately 150 million American workers and their dependents have health insurance today through their employer. An additional 20 million are self-insured. Government is the health insurance provider for nearly 34 million Medicare beneficiaries and another 23 million Americans who rely on Medicaid for their health care. The remainder -- almost 34 million of our fellow citizens -- have no health care coverage at all.

Even though approximately 227 million Americans have some form of health insurance, Americans of every income level are worried. The ranks of the uninsured or inadequately insured are growing steadily while the costs of health care skyrocket. Polls tell us that when it comes to health care, middle-class Americans are most frightened of losing coverage or facing a catastrophic illness that could wipe them out financially. They are asking for our help, and they deserve our best efforts.

Coverage and access issues are not the only problems. The American people also want us to come to grips with the

astronomical costs of health care. As long as we allow health care costs to continue to rise at eight to ten percent a year faster than the rate of inflation -- as long as health spending consumes 12 percent or more of our gross national product -- economic doomsday is just around the corner. How can America hope to compete in the world economy if more and more of our national resources are being consumed on health care? Clearly, real cost control must figure prominently in any reform effort.

The debate on how to provide universal health coverage will be a tough one. There are no cheap or easy answers and, at the moment, there is no broad consensus.

My bill -- H.R. 3205 -- proposes one answer. It is comprehensive, responsible, and realistic, phasing-in a "pay or play" health insurance system which would require each employer to choose from one of two options. Employers would either provide private health insurance to all employees and dependents that meets certain minimum standards, or pay a payroll tax that would help finance a public health insurance plan to cover those employees. At the outset, the payroll tax would be set at 9 percent of the Medicare wage base and indexed to the rate of growth in health benefits covered by the program.

The plan would be phased-in, starting first with larger employers, gradually adding smaller employers, and ultimately covering all citizens by the fourth year. Employers and employees would share the cost, with at least 80 percent paid by the employer, the remaining 20 percent by the worker.

Benefits under the plan would generally be the same as those available under Medicare. However, deductibles would be limited and a cap would be set on out-of-pocket medical expenses to protect families from huge medical bills they can't afford. Children's benefits and a pregnancy package would be added to the usual Medicare benefits, as would certain preventive services.

Another important feature of the bill is a gradual reduction in the age at which Americans qualify for Medicare. Under the bill, the age would be decreased annually from 65 to 60 over five years, providing significant new benefits to many early retirees and relieving many employers of a growing portion of their retiree health care liability.

H.R. 3205 also includes tough new cost containment provisions that set annual targets for the rate of increase in the costs of overall health benefits. In large measure, the American people will judge the success of any health care reform effort by whether we can actually control costs. It's up to us to deliver.

I have suggested paying for these benefits with a three part revenue package that increases the Medicare wage base and raises the Medicare tax rate, imposes a gradually increasing surtax on individuals and corporations, and asks States to contribute to the new system those funds they otherwise would have spent on Medicaid.

History tells me that we cannot underestimate the difficulty of reforming the health care system. I have been in Congress for more than 32 years, and am one of the few Members left who voted to create Medicare in 1965. That victory didn't come easily.

The fight to create what later became Medicare and Medicaid had some very heavy hitters on the side of reform. The Ways and Means Committee began the debate with comprehensive hearings in 1958 and 1959. Health care for our senior citizens became a major campaign issue during the 1960 Presidential debates. Momentum built after the tragic assassination of President Kennedy and the subsequent landslide election of President Johnson, who viewed his election as a mandate for health care reform. Even with all that political commitment, it still took more than five years to accomplish. And even then, with the enactment of Medicare and Medicaid in 1965, we only solved part of the access problem.

We are likely to find ourselves in a similar situation this time around, knowing that we need more comprehensive reform, but unable to quickly develop a political consensus to enact such a sweeping reform package, especially in the absence of Presidential leadership. If that proves to be the case, we ought to begin thinking about the incremental next steps that should be taken to both further debate and, equally importantly, make progress in solving the health care problems facing our country.

I think H.R. 3626, an incremental health insurance reform bill I introduced last week with Senator Bentsen, offers a reasonable incremental solution.

Many of today's uninsured are members of middle class families working for employers who happen to have a relatively small business. Many small businesses simply cannot afford to buy health insurance for their employees.

H.R. 3626 offers a step in the right direction: reforming the small group health insurance market to improve the availability and affordability of group health insurance. It would establish basic Federal standards for small group health insurance, including anti-discrimination requirements, guaranteed renewability, and rating requirements.

H.R. 3626 would also address the serious problem of "job

lock," which happens when workers stay in their current jobs because they can't risk losing health coverage for pre-existing conditions when they change jobs. Other provisions include a 100 percent tax deduction for health insurance costs of self-employed individuals, significant cost control through the establishment of optional Medicare-based payment rates for health services, and important new prevention benefits in Medicare.

This new incremental bill will make important, but admittedly limited, improvements in the health care system. The bill is not intended to be a substitute for comprehensive reform. I have proposed this incremental bill in the hope that it will jump-start the legislative process, getting all of us -- the Congress and the Administration -- on the road toward more comprehensive reform.

I believe there is no more important problem confronting our country today than health care. Nothing cries louder for a solution. Nor is there anything I would like to do more than to assure my constituents in Chicago and Americans across this great country that they will receive necessary care when they are sick. People who are ill should worry solely about getting well. They shouldn't be worried about the bills that are piling up.

But we must keep two things in mind.

First, absent Presidential leadership, we will not be able to achieve a major reform of the health care system by ourselves. If that means using next year to challenge the President to debate, so be it. If all we accomplish is making health care the cornerstone issue of the next Presidential election, that's fine. President Bush is wrong to duck this issue. The American people are asking for our help -- soon they will demand it.

Second, if we are going to be taken seriously, we have to confront health care reform in a fiscally responsible manner. And we should not overpromise. Our job is to present the American people with a solution to the health care crisis that we think we can afford. The American people will decide whether the benefits are worth the sacrifice. But until then, millions of Americans are waiting for this Congress and this President to act. They deserve no less than our full commitment to solving the critical problems of both access and costs.

I look forward to working with this Committee in the pursuit and ultimate enactment of comprehensive health care reform legislation.

Mr. WAXMAN. Our next panel includes very distinguished health policy analysts who have conducted extensive research on health care costs, and, in their roles advisers to Congress, they have been called upon to recommend specific cost containment policies.

In many respects, these individuals have been on the firing line on this issue. They have had the opportunity to evaluate experience with alternative cost approaches.

We have asked the panelists to give us the benefit of their experiences, and comment on the cost containment proposals included in the various bills on our subcommittee.

Our first panelist is Dr. Altman. Doctor Altman has served as chairman of the Prospective Payment Assessment Commission since its inception, and he has held a number of senior government positions. He will be followed by Dr. Karen Davis, professor and chair of the department of health policy and management at Johns Hopkins University and member of the Physician Payment Review Commission. Dr. Davis, who is an economist, previously served as a Deputy Assistant Secretary of HHS. Third, Dr. Herdman, Assistant Director for Health and Life Sciences at the Office of Technology Assessment. Prior to assuming his OTA responsibilities, Dr. Herdman was vice president of the Memorial Sloan-Kettering Cancer Center in New York.

Your full written statements will be a part of the record in their entirety. We would like to ask, if you would, to limit your oral presentation to no more than 5 minutes.

Dr. Altman.

STATEMENTS OF STUART H. ALTMAN, CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; KAREN DAVIS, COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION; AND ROGER C. HERDMAN, ASSISTANT DIRECTOR, HEALTH AND LIFE SCIENCES DIVISION, OFFICE OF TECHNOLOGY ASSESSMENT

Mr. ALTMAN. First, thank you.

First, let me indicate I have been the chairman of the Prospective Payment Assessment Commission since it began in 1983.

The issue of rising health care cost has been an issue we debated and discussed. However, we focused our attention primarily on the Medicare program and PPS system.

Since you asked us to take a broader view and to present opinions dealing with overall expenditure limits, I didn't feel it was appropriate to represent the commission, so, if you will allow me, I would like to represent myself.

I will, if asked in time, bring up research we have done in connection with ProPAC.

Let me make it clear, this is not the consensus of the commission in any way, although I think I have a few people that would support where I come from.

I will present my entire testimony, in which we go through what my—our views are with respect to what is causing the rise in health care cost. Let me summarize.

What is clear to me and the research we have done demonstrates it, we have gone through the last 20 years seeing our percentage of

GNP rise as dramatically from around a little over 6.5 percent to 12.5 percent.

Every indication right now is by the turn of the century we will significantly be above 15 percent. We are now talking about 16 or around 16.7 percent. The new estimates are that we will be something in the order of in excess of \$1.6 trillion.

I know we are having a flat debate whether it will be 1.6 or 1.7. I don't even understand what a trillion dollars is. What is clear to me, if you look at our ability to control these increases, they have not been very significant.

We, as a country, have tried more things than any other country in the world. We tried incentives, we tried different forms of delivery system. We tried halfway regulations. We have done everything. What is clear, we have never really come up with a flat policy, as Mr. Wyden has indicated, where we sort of make it very clear we have some limits on what we can experience; and remember, we are to allocate them in a way that give us the most efficient use of those dollars.

When we look at what has happened, what we have seen is a tremendous passing of the buck. We recently did a study of ProPAC which looked at who is paying what.

What we found is if you take for hospital care the average cost of care, uncompensated care, is probably paying around 30, 34 cents on the dollar in terms of what it costs to provide that care. Mostly that 30 cents coming from State and local government.

Medicaid is fast approaching on average 70 percent, which means 30 percent of the Medicaid services are being paid by someone other than the Medicaid program at the hospital level. Medicare is around 90 percent or about 10 percent of cost.

American corporations are now paying a hidden tax of about 30 percent. In other words, 30 percent markup is being put on health insurance premiums for the private pay patients.

Now, saying that doesn't mean I am opposed to that 30 percent, given the fact if we took it away, our health care system would collapse. But it is not the way to go. What it demonstrates is every major payer group is trying to figure out a way not to pay their share, because their share is getting to be so heavy a burden they are trying to figure out a way to pass it on to somebody else.

When our two biggest payers aren't paying their share, you are increasingly asking corporate America to pay it. That is why large corporations, large unions are coming before you and say we need serious reform.

This is a very new position for them to be in. They are now willing to come, and I think enter into some serious negotiation with you and the Congress and the States and the providers to come to some consensus or where we need to go.

When we look at the kind of payment systems we put into effect, the DGRPPS system is working, but in a very haphazard way. Medicare is not the only payer in town. So that hospitals are shifting the costs. And, in fact, many of the decisions in the hospital industry are not made by the hospitals, they are made by the doctors, and the PPS system doesn't control the doctors.

So hospitals themselves feel helpless to deal with this issue. So what it all comes down to, I believe we need to do something that

was never done before, and that is to make a commitment at the national level to control total spending for health care.

There are many proposals out about tying it directly to GNP, and in fact saying, like other countries, we are not going to spend more than 12 percent, 13 percent, find out what that amount is and then allocate it back. I think that is too rigid a structure. But I do think a discipline needs to come into the system that we have never seen.

My proposal would be to put together what I call a National Health Expenditure Board. I think this National Health Expenditure Board should be set up by the Federal Government. I think it should have powers given to it by the Federal Government. But I think it should operate from the day-to-day operations of the Federal Government.

I have likened it to a Federal Reserve Board type of structure for health care. I think it should have representatives from Government. I think it should have representatives from the major payer groups, labor unions, corporations. I think it should have representatives from hospitals and from doctors, but it ought to have a clear mandate from the Congress which says, you give us directions on how to allocate the money, but don't come up with a set of payment rates which are going to lead us to exceed some amount of money. You tell us what that amount is.

That doesn't take control away from the Congress. You ultimately would be responsible for what you pay under Medicare and this new financing system.

I believe in a pay-or-play financing system. I know there is a lot of argument whether it should be a single payer or a multiple payer system. I believe it should be a multiple payer system and to maintain as much of the strength of our existing system it can, but that everybody in the system be under the same structure, that we don't have this pass the hot potato game that we have today.

Mr. Kirkland pointed out that it is a jungle, and a jungle is where the strong eat up the weak. The powerful groups, including the Government, are sort of pulling themselves in. We say, okay, you give Medicare people 100 cents on the dollar, but we are going to pay 90. Who is getting it in the neck are actually small corporations and individual payers.

So I believe we should have a common payment system structure. It doesn't mean everybody pays the same amount, but that there be a common structure that links them together. And this expenditure board would help dictate what the amounts would be.

I also believe we should allow some State flexibility under this national system. I think the interesting activities that are going on in Oregon and in Massachusetts and New York and Maryland and California should be allowed to germinate and give us direction for the future. But I would be very careful about giving these State systems total flexibility. They should work under some national mandate.

And what is most important is that everybody have access to health insurance and that the system be paid for in a relatively fair way through some balancing mechanism of taxes.

But what is most important is that we combine equal access, 100 percent access, with a commitment for cost containment. We can't get either/or. I think the time has passed.

I know there are a lot of people, including people on this subcommittee, that want to see access first. There are millions and millions of other people that want to see cost containment first and will worry about access later. I think the time has past for either/or. We are going to have to put together a system which links them together.

I am not a politician, but I try to keep abreast of what the public is thinking, and you can see health care is zooming up the charts. More and more middle-income Americans are really scared. They are scared they are going to wake up tomorrow without health insurance protection. That is what Mr. Kirkland said, that is what your polls are saying, and as someone who knows personally, it is become a real issue that cuts across income extremes.

I hope in this session of Congress or the next, we really get down to making the system work.

Thank you very much.

[Testimony resumes on p. 265.]

[The prepared statement of Mr. Altman follows:]

Stuart H. Altman, Ph.D.
Chairman

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Dean of the Heller Graduate School of Social Policy at Brandeis University and Chairman of the Prospective Payment Assessment Commission. I am accompanied by Dr. Donald Young, the Commission's Executive Director.

I am pleased to appear before the Committee this morning to discuss the important subject of rising health care costs and the strategies to control these costs. Although rising health care costs is a subject with which ProPAC staff has devoted substantial time and understanding, and the Commission itself has discussed the issue at several meetings, ProPAC has never undertaken an official position on what are the major factors causing the rapid growth in spending. Or, more importantly, what type of strategies should be undertaken to curtail them. Therefore, I am testifying this morning as an individual and not as the Chairman of the Prospective Payment Assessment Commission.

Health Care Spending

Despite many cost containment initiatives, from 1980 to 1990 national health care expenditures increased more than two and a half times to \$671 billion. This rate of growth has far exceeded the growth in our national income, and, as a result, health spending as a percent of national income has grown from 9.1 to 12.2 percent. These aggregate growth rates hide the significant changes in the distribution of spending that will affect any efforts to control these costs.

Hospital services have always accounted for the largest component of health care expenditures. From 1980 to 1989 spending for hospital services increased from \$102 billion to \$233 billion. Nevertheless, the share of spending for all inpatient and outpatient hospital services declined from 47 percent to 44 percent, with the relative growth in spending for acute inpatient hospital care declining even more rapidly. Spending for hospital outpatient, physician, and other ambulatory services, on the other hand, increased substantially.

Shift from Inpatient to Ambulatory Care

The decreasing use of inpatient hospital services, together with the extraordinary growth of ambulatory services, has positive and negative effects on the costs of care. While shifting patients from inpatient to outpatient settings resulted in substantial savings in the costs of services furnished to those individuals, the overall positive impact on hospital costs was less dramatic as fewer patients were available to shoulder the high and growing fixed costs for the inpatient hospital system.

Meanwhile, expanded outpatient services capacity, together with medical advances, resulted in many additional patients receiving services, thereby increasing overall spending.

Factors Responsible for Spending Increases

There are four factors, Mr. Chairman, that account for the increase in spending for health care services. These are population growth, inflation in the general economy, additional inflation specific to health care, and increases in the amount and intensity of services furnished. I will briefly describe each of these factors and then discuss the strategies that have been used to attempt to control costs. As I mentioned previously, in the aggregate these strategies have not been very effective, and I will next discuss why they have not worked and the implications for future payment reform.

Population Growth

The first cause of increased spending is population growth. The U.S. population has been growing about 1 percent a year. In addition, the population is aging, with the Medicare population growing almost 2 percent per year. The increased number of people, together with aging of the population, can be expected to result in a continued 1 to 2 percent annual increase in health care spending.

Price Inflation in the General Economy

The second factor is economy-wide price inflation. This general inflation affects the price of labor, goods, and services purchased by health care providers and practitioners. As you can see in Figure 1, in the past 10 years economy-wide inflation added between 2.8 and 9.7 percent to the annual growth in health care spending. For hospital inflation this translated into about 40 percent of the annual increase in hospital operating expenses per admission between 1985 and 1989 (see Table 1).

Figure 1. Reasons for Growth in Personal Health Care Expenditures, 1980-1989

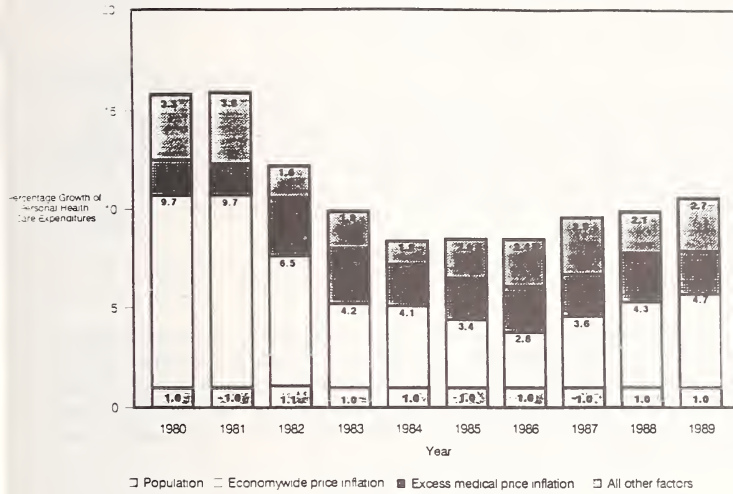


Table 1. Factors Contributing to Annual Increase in Operating Expenses Per Admission, 1985-1989

Factor	Percent increase	Percent of Total
Inflation:		
General economy inflation	3.5%	40%
Health care inflation	1.5	17
Patient care:		
Patient complexity	1.9	21
Intensity of services furnished	1.8	20
Hospital inputs:		
Employee skill-mix	0.1	1
Mix of non-labor supplies and services	0.7	8
Service-level/labor productivity	-2.5	-17
Total:	8.9	100

While hospitals and other providers must compete in the general economy for labor, capital, and supplies, they do have control over the levels and types of inputs they purchase and can respond to inflation by becoming more efficient and productive. For hospital inpatient care, this did occur to some extent.

Between 1985 and 1989 hospitals produced individual services more productively. That is, they used less hours of nursing and other personnel time to produce the same set of services. Without these productivity improvements, hospital costs per case would have increased an additional half a percent a year. As I will discuss in a moment, however, improvements in producing individual services have been overwhelmed by the increase in the total number of services furnished to each patient.

Medical Price Inflation

The third factor responsible for cost increases is the additional increase in the price of goods and services specific to the health care sector. For example, nursing wages have increased at a faster rate than labor costs in the general economy, and annual price increases for drugs have been two to three times greater than general inflation. Medical price inflation in the past decade has added between 2 and 3 percent to the annual increase in health expenditures.

The ability of manufacturers and suppliers of medical services, products, and drugs to pass higher prices on to the medical sector is in part related to the ability of health care providers to absorb these increases by passing them on to the payers of health care. There is also the question of whether workers in the health care sector should continue to receive wage increases or compensation levels substantially higher than workers in other sectors of the economy.

Intensity of Patient Care Services

The fourth factor responsible for growth in spending is the amount and quality of the services furnished. This factor is referred to as intensity and includes more surgery, diagnostic tests, physician visits, and other services. In the past decade the complexity of patients treated and of their treatments has increased substantially due to medical advances in fields such as transplantation, cardiology, and cancer treatment.

Increases in the intensity of services added between 1.2 percent and 3.6 percent to the annual increase in personal health care expenditures in the past 10 years.

It is in the area of service intensity that major reductions in the cost of care may be found. We simply don't know how much service intensity adds to the quality of patient care and to improved health outcomes.

Strategies to Control Costs

Numerous approaches to control increases in health care spending have been implemented by government and private payers in the past decade. While these strategies have helped control the expenditures for specific types of services or for specific groups of payers, they appear to have had little impact on the overall growth in spending.

I will first describe some of the strategies that have been used and then discuss why they have had little impact on system-wide spending.

The government and private third party payers have attempted to control both the price of individual units of services and the overall volume of services. One frequently used strategy is to move from cost or charge based payment to systems where payment amounts are set in advance. Many of these systems, such as physician and laboratory fee schedules, focus entirely on the price of an individual service. While some have been successful in slowing the rate of price inflation they appear to have pushed the volume of services provided to even higher growth.

A second strategy attempts to control price and volume by bundling related services together and setting a prospective price for a group of services. Examples of such approaches include an annual capitation payment for all the services furnished by an HMO over a year and bundled payments such as DRGs for all inpatient hospital services during an admission.

Prospective payment strategies that rely on bundling generally have two objectives. One is to reduce the immediate costs to the specific payer such as Medicare or an insurance company. The second is to provide financial incentives to providers to reduce their costs of furnishing services and therefore to reduce overall health care system costs.

A third strategy, referred to as managed care, uses a combination of financial incentives and utilization controls for individual services or groups of services.

A fourth strategy attempts to control spending by requiring a higher level of beneficiary cost sharing. Their strategy may be in the form of higher deductibles and copayments for all services or for selected services or selected locations.

The Success of these Strategies

My assessment, Mr. Chairman, is that despite the cost control strategies that have been employed over the years, health care spending continues to increase about 5 percent each year above the increases to be expected from population growth and inflation in the general economy. While government and private payers generally have been able to control the price they pay for individual services and packages of services, such as an inpatient hospital admission, they have been less able to control their total spending. Frequently, savings on the price of services has been offset by increases in the overall volume of services provided.

In some inpatient instances even when a particular payer, such as Medicare, has been able to reduce its total spending for a service, providers have shifted added costs onto other payers and as a result there have been little savings in overall health care system spending.

The inability to effectively control the continuing increase in health care costs for the nation is related to two aspects of the American health care system. First, no single payer, including Medicare, has sufficient market power to force substantial reductions in hospital and other provider expenses. Second, controlling spending for one payer or one type of provider frequently does not result in system-wide cost containment because of the way in which expenses can be shifted to other payers.

The experience of the Medicare prospective payment system illustrates the difficulties in achieving system-wide cost containment. ProPAC, the Congressional Budget Office, and others have clearly shown that the rate of increase in Medicare program spending for acute hospital care as well as spending for each admission has slowed substantially since PPS was implemented. Most analysts believe that Medicare now pays substantially less than it would have under the previous cost-based system and in fact less than what it actually costs to furnish inpatient services to Medicare patients.

Despite the financial pressure of Medicare PPS to control hospital expenses, the effects are limited because hospitals are able to offset Medicare shortfalls by increasing revenue from other services and from other payers. Consequently, even a major payer, such as Medicare, has not been able to control the annual increase in hospital costs per admission.

In addition, while Medicare controlled its program costs for acute inpatient hospital care, Medicare spending for hospital outpatient, rehabilitation, and other ambulatory services has grown rapidly. Thus, Medicare savings on the inpatient side are offset by the growth in spending for other services.

This occurs because the American health care delivery system can quickly develop the capacity to furnish additional services if financing is available. And our health care financing and insurance system continues to pay for the increasing number of services furnished. Our insurance system, for those who are covered, has accomplished its goal of protecting individuals from the high cost of illness. It has also insulated individuals and providers from most of the financial implications of their decisions.

In addition, our financial incentives frequently work at cross purposes. While hospitals face financial incentives to decrease the number of services furnished to an individual during an admission, physicians generally have incentives to increase individual services.

Up to now, the pluralistic nature of our health care delivery and financing system has been highly valued by the American public. No single governmental or private payer, provider, or physician can control our total spending nor can any one provider or provider group control the total services furnished to an individual. Further, there are countless examples that the American public, insulated from many of the financial implications, wants the newest and most advanced services and has placed high value on the freedom to choose among available payment systems and providers to obtain care when they feel it is necessary.

Clearly something has to give. Pluralism, individual freedom to choose a provider, and effective health care cost containment are, in my view, ultimately incompatible. Every other Western country has chosen to limit either the number of payer units or to control the use of services. The debate that is taking place in this country today on the most effective method for controlling health spending centers around whether through regulation we should limit our pluralistic payment system to some version of a single payer approach or whether we should restrict individual freedom of choice of patients to choose their health care provider in such a way that competition would take place between a limited number of provider units and where major payers such as corporations and the government would contract with these limited number of provider groups based on the quality of the care they provide and the cost effective way they produce it.

In my view, truly effective competition among provider units would require such a change in the way most Americans receive their health care that total reliance on this approach will ultimately lead to what I have called "halfway competitive markets." Such halfway competitive markets often generate the worst of both worlds. They do force individuals to change their way of receiving medical care somewhat, but they do not generate the expected savings. The decade of the 80s has demonstrated all too many examples whereby the savings resulting from reduced utilization have been more than offset by added expenses for advertising, administrative costs, and added payments to entrepreneurs who have put such systems together. Proponents of competitive delivery systems recognize the limitations of the approaches of the 80s.

but argue that substantial savings could happen in the future if we truly implemented fully competitive systems. Perhaps they are correct that truly competitive systems would generate the desired savings. But there is no indication that the American public would accept that much of a change in the way they receive medical care.

I therefore believe that an effective cost containment system in the United States must include limitations on the pluralistic nature of our health care financing system. Such a system need not have a single payer, namely government, but it must have all payers integrated into a common and controlled financing system. Such a controlled all payer system can be organized at a state level, but I believe there should also be an overall national structure which assures some degree of equality between regional systems. This controlled all payer system should allow sufficient flexibility for a limited form of competition among organized delivery systems. But such competition needs to be placed in a context of an overall control in our financing units.

Included in this system should be a set of restrictions on how capital is generated and used in upgrading and expanding our health care system. One of the aspects of the American health care system which separates us from other countries is the degree to which we have allowed new and expensive technology and delivery systems to proliferate throughout the country with very few economic restraints. No other country allows such uncontrolled growth. I also believe such a capital control system must integrate the knowledge that is being generated about the types of medical interventions that have proven to be effective or conversely the types of interventions that have been shown to be either useless or in some cases even harmful. Linked to the use of these appropriate medical strategies should also be a limitation on the degree to which individual patients can sue health care providers for failure to use every possible intervention. Malpractice rates have directly and indirectly been an important component of the rise in medical care costs over the last 20 years. While providers should not be shielded from negligent practices, they should be protected against suits which hold them accountable for providing services that are considered to be in excess of what is believed to be acceptable medical practice.

Limits on Spending

I am normally not a strong supporter of central controls or any form of national expenditure limits. But, as I indicated previously, the 1980's have taught us that attempts to limit one sector of the health system leads to a shifting of the expenses to other sectors. This is dramatically illustrated by the fact that almost 30 percent of the increase in private sector health insurance premiums for 1990 were estimated to be a direct result of providers shifting the expenses of uncollected bills onto this sector of the system. Therefore, Mr. Chairman, I strongly support the inclusion of a national health expenditure limit and a single payment system for all payers in any form of a health care reform.

I would suggest, however, that such a national health expenditure limit not be a rigid formula tied to our growth in GNP after the first few years. Rather, I would advocate that the target limit be established by a "National Health Expenditure Board." Because these expenditure limits would be all inclusive and include limits on both public spending and private spending, membership on the Board should include representatives from both the public and private sectors. I believe such a system would work much better if it was outside the day-to-day purview of the Administration and therefore would suggest that it be set up as an independent agency of the government, perhaps similar to the Federal Reserve Board. Membership on the Board would come from the Administration, Congress, and organizations designated in the legislation to represent providers, private insurers, business, and labor.

Congress would ultimately be a major determiner of the total budget because it would need to approve the federal component of the spending limit. Similar to the Federal Reserve System, there could be regional or state level units which would create budgets for their regions.

A critical component of such national or state budgets would be the establishment of payment rates which must be used by all payer groups so as to eliminate the current practice of cost-shifting against those groups with "deeper pockets" and/or weaker market power. These rates should be set so as to constitute payment in full for all services covered under either the mandated plan or through the government programs. I would not go as far as in Canada and make extra billing by physicians illegal, but I would create strict limits on extra billings and not permit any private insurance coverage for such extra billings. This is the approach used in Australia, which has a comprehensive government supported health financing system with extensive extra private insurance. Such private insurance, however, cannot be used to pay for the extra billing by physicians.

While I would not create through legislation a strict link between the national expenditure budget and the U.S. GNP because of the changing demographics of our population as well as the potential medical value of new high cost technologies, I do believe the long-term goal should be to have national health expenditures grow in relationship to our ability to pay for it from growth in national income. Because of the need to establish limits immediately, however, I would support increasing restrictions in expenditure growth for the first four years. I also support for the short-term the use of the Prospective Payment System methodologies for hospital payments and the Resource-Based Relative Scale. In the long-term, the National Health Expenditure Board and/or the states should have flexibility to adopt alternative approaches to paying providers. The alternative systems, however, should be subject to approval by the National Health Expenditure Board to insure that they are not designed to give a competitive advantage to one group of payers over another.

Implementing health care system reform such as I have described will not be easy. Opposition to change is likely from one part of the health care system or another. A strategy that effectively controls the overall rate of growth in health spending will reduce the price and/or amount of labor, supplies, and services used to produce health care services as well as the administrative and overhead costs and the incomes and profits associated with our health care system.

Fears that effective cost containment strategies will threaten access to high quality care will be raised. Concerns will be voiced regarding the availability of technologically intensive services such as transplantation, advanced cancer treatment, and trauma care. We will also hear that innovation and the development of potentially curative or cost-effective drugs and technologies will be stifled and that cost containment may reduce the incomes of nurses, technologists, and other personnel and staff shortages will occur as workers choose other higher paying careers.

But these concerns must not dissuade you from moving forward to design a truly comprehensive national health plan this country can afford. To do that it is imperative that any all-encompassing financing system be linked with an effective cost containment strategy such as those I have outlined. I realize that big numbers come easily here in Washington and we have become used to talking about billions of dollars when we speak about the amount this nation spends for health care. But, Mr. Chairman, even conservative estimates indicate that by the year 2000 this nation will be spending at least \$1.5 trillion for its health care which will consume 15% of our GNP. If present trends continue this number could reach \$1.8 trillion. What this will mean is that fewer companies will be able to afford comprehensive protection for their workers and families. We will almost surely witness the number of uninsured exceeding 40 million and it could even reach 50 million. For those insured, benefits will be cut back and patient cost sharing will grow substantially. For taxpayers, the cost of Medicare and Medicaid programs will continue to grow much faster than the current tax base, requiring further increases in the Medicare payroll tax plus added state taxes or further cutbacks in other state services. And the litany goes on.

While I can't tell you at what point the entire structuring of our existing health financing system will crack under constant double digit inflation, 15 to 20 percent of our total national income for one service--important as it may be, is an incredible amount. Every other western democracy has kept the percentage of its national health spending for health care under 9%. If others can do it, so can we. While I'm not suggesting we should or can roll the clock back to 9% of our GNP, we can try to stabilize growth over time in relationship to growth in spending to our growth in national income.

In conclusion, Mr. Chairman, Congress must not let those who glibly recite all the negatives of health care cost containment stop you from moving forward. Because, I am afraid, if you don't do anything, just those negative consequences they suggest will befall our current system.

Mr. WAXMAN. Thank you.
Dr. Davis.

STATEMENT OF KAREN DAVIS

Ms. DAVIS. Thank you, Mr. Chairman and members of the committee. I am pleased to have with me today Paul Ginsberg, executive director of the Physician Payment Review Commission.

Action in this area I think is very urgently needed. I compliment you on holding these hearings and beginning the process of considering such legislation.

Today I would like to talk about the work of the Physician Payment Review Commission on health care costs. I would like to look at what we know about the effectiveness of cost containment, building not only on the work of the Physician Review Commission but the excellent work of the Congressional Budget Office and Congressional Research Service, and then I wanted like to turn to some of the proposals for health care reform and make some comments on their features that relate to cost containment.

As you know, the Physician Containment Review Commission has devoted its energies towards the development of the Medicare physician reform proposal which has now been enacted into law. That proposal has several features.

It institutes a resource-based relative value schedule for the payment of physicians under Medicare. It sets limits on any balance bills that physicians may make to Medicare beneficiaries, and it includes based upon a recommendation of the commission, a volume performance standard that sets a perspective limit on total expenditures under the Medicare program.

We believe that that approach will be a very important step toward controlling costs for physician services in the Medicare program, and as Mr. Altman has said, the perspective payment system that came in for hospitals in 1983 had had a dramatic effect in slowing the rate of growth of expenses of hospital care.

With the volume performance standard, the commission has been making recommendations about how to set those overall limits on expenditures, and our long-term objective is to slow the rate of growth in Medicare physician outlays to the rate of growth in the gross national product over a 5-year period, so we have made an explicit goal to slow that to that rate of increase.

In the Omnibus Budget Reconciliation Act of 1990, the Congress further asked the commission to look at options to constrain the costs of health care to employers, including incentives under Medicare.

In our 1991 report we had a chapter devoted to how the private sector could use the Medicare resource-based fee schedule, either voluntary or how you could build on the Medicare system to institute an all payer system. That report discussed a little bit the experience of Germany, which has used an all payer-physician payment system, with an overall expenditure limit to control physician spending.

The commission plans to continue to explore the potential of all payer approaches and we are currently analyzing what data would be needed to initiate and update them.

Turning more generally to the problem of rising costs of health care service, many people attribute it to demographic factors. In fact, what we know from research is that demographic changes account for only a small part of the increase in health care costs. Less than 1 percent a year can be attributed to that. Some of it is change in medical practice, development in technology, increases in physician supply. But there is also a considerable body of research that shows that there is a lot of unnecessary utilization of health care services, overtesting, overuse of procedures.

We have found that the research shows that prices can be constrained by more aggressive purchasing on the part of payers, Government regulation of prices. Certainly we think there is evidence to suggest that as Medicare has tried to limit fees, that that is in the past already had an effect, and has saved the Medicare program money.

In the private sector, there is a lot of emphasis upon preferred provider organizations, or PPO's, to get price discounts. There the evidence is somewhat less clear. Those systems have significant administrative costs. Typically, they give financial inducements to employees or others to choose PPO providers, and it can lead to cost shifting as those providers raise fees or costs. There is certainly less clear evidence on the savings from the PPO mechanism.

But while it is clear that Medicare through payment reform can have an effect on cost for its beneficiaries, there are limits to how much one can work on just a single part of the system without being concerned about access to care for beneficiaries.

The commission has also looked at the Medicaid program, and we found there that Medicare pays physicians about 64 percent of what Medicaid pays physicians, and in many States much lower than that, and by controlling the fees excessively, there has certainly been a problem with access to care.

Therefore, we support the idea that to do an effective job at controlling costs, we need a comprehensive approach that doesn't focus on one program, but really looks more vigorously at an all-payer approach to physician payment reform, such as the one in H.R. 2535.

Certainly other countries such as Canada, Germany, have tried, either through a single payer like Canada or an all payer system like Germany, to control costs. And we are continuing to work on those approaches and to design such a system.

Other approaches to cost containment include trying to limit volume through cost sharing. While there is some evidence that if patients have to pay, they will get less care, there is also evidence that that mechanism is not very effective at differentiating necessary or important care, but tends to, in fact, pose a barrier to care, particularly for low-income people.

Health Maintenance Organizations, again, some good evidence of cost saving from that approach, particularly looking at the original prepaid group practice model. However, the commission has some concerns about the newer types of HMO's that pay individual physicians on an individual capita based basis, and have raised concerns that such strong incentives to contain costs could limit appropriate as well as inappropriate services.

We have looked at some of the evidence and research on administrative controls or utilization review, and while there is some evidence of some success in that area, many times the savings are offset by the cost of administrative mechanisms to review the utilization, and many times it has resulted in shifting costs to patients. Further, physicians in many cases get frustrated by the hassle that those administrative systems impose.

We believe a better approach is to develop practice guidelines so that physicians can practice in a more cost effective manner if they have better information, and we certainly supported the creation of the agency for health care policy and research for expanded funding for health outcomes and effectiveness research.

We believe more broad economic research through overall expenditure limits, coupled with information on what are effective services, in combination, can be an effective approach to cost containment. We do have some work under way on malpractice, looking at not only tort reform, but other kinds of additional options, such as administrative mechanisms in place of judicial proceedings to deal with some of the issues there.

However, we do think the greatest promise is in the area of comprehensive health care reform. Such reform can more effectively control costs by having a coordinated approach across a number of payers: Medicare, Medicaid, and private payers. Such all-payer approaches precludes the ability of providers to shift cost to other payers and also precludes the risk to beneficiaries of limited access to care.

So we think proposals such as your H.R. 2535, Mr. Rostenkowski's proposal, 3205, are very important approaches to this that need to be given careful consideration. Under H.R. 2535, private payers would have the option at paying at Medicare rates which would continue to be set under current law.

Under Mr. Rostenkowski's proposal, rates would have to be consistent with factors tied to the gross national product. Given the potential to these mechanisms to limit price increases more effectively, these proposals are an important contribution to the coming debate on cost containment.

In summary, the commission is just beginning its work on the relationship between Medicare policies and employer attempts to contain costs. Its initial efforts have focused on the use of the Medicare fee schedule for private purchasers, whether on a voluntary basis or as part of an all-payer system.

We have begun to look at the data requirements of what you would need to institute an all-payer approach to physician service, and this has proved to be an all important area. So we will be pursuing our activities in this area and we look forward to working with the committee and its staff as we pursue our work.

Thank you.

[The prepared statement of Ms. Davis follows:]

STATEMENT BY THE PHYSICIAN PAYMENT REVIEW COMMISSION

by

Karen Davis, Ph.D.
Commissioner

Consideration of proposals for health care reform has increasingly begun to focus on options to contain costs. Cost containment is important because existing programs are straining the ability of taxpayers, employers, employees, and individuals to pay for care. Expansion of coverage to those currently uninsured will likely add to this strain. Fortunately, health care reform provides the opportunity to consider cost containment options that have not been feasible under current financing mechanisms.

My statement begins with a description of the work that the Physician Payment Review Commission has completed or has underway that is related to cost containment. Then, from a health system perspective, I outline the various approaches to cost containment and what the experience has been. I will draw on both my personal understanding of the evaluation literature on cost containment, which has been aided immeasurably by the excellent reports prepared for the Congress by the Congressional Budget Office and the Congressional Research Service, and on the Commission's experience with Medicare cost containment and with physician payment policies in state Medicaid programs. Finally, I briefly consider the potential for health care reform to enhance cost containment efforts.

WORK OF THE COMMISSION

Almost from its inception in 1986, the Physician Payment Review Commission has been concerned with approaches to slow the rate of increase in expenditures for physicians' services in the Medicare program. In 1987, the Congress asked for advice on how to cut outlays for physician services and the Commission recommended a series of price reductions designed to alter relative values in the direction of what would eventually become the resource-based Medicare Fee Schedule. In response to a subsequent mandate to advise Congress on methods to slow growth in the volume of services paid for by Medicare, the Commission in 1989 proposed that fee updates be based on an expenditure target mechanism. Later that year, as part of Medicare physician payment reform legislation, the Congress enacted a version of this mechanism called Volume Performance Standards.

The Commission has continuing responsibilities to make annual recommendations to the Congress on both standards for rates of expenditure increase and fee updates. It made such recommendations in 1990 and 1991, guided by a long term objective to reduce the rate of growth to that of GNP over a five-year period.

The Commission also recommended federal initiatives to work with the medical profession and researchers to develop practice guidelines. When it created the Agency for Health Care Policy and Research (AHCPR), the Congress directed it to undertake such a program. This year, the Commission plans to assess the Agency's progress to date in developing practice guidelines and advise the Congress on changes in direction if called for.

When the Omnibus Budget Reconciliation Act of 1990 broadened the Commission's mandate, it expanded its responsibilities in cost containment beyond the Medicare program. Specifically, the Commission is to consider options to constrain the costs of health care to employers, including incentives under Medicare. In its 1991 Annual Report to Congress, the Commission described how Medicare's resource-based fee schedule could be employed by private payers,

both voluntarily and under an all-payer rate setting mechanism. It also reported on how Germany uses an all-payer mechanism to set payment rates and review the quality and appropriateness of care. The Commission plans to continue to explore the potential of all-payer mechanisms and is currently analyzing what data would be needed to initiate and update them.

EXPERIENCE WITH COST CONTAINMENT

The debate over alternative approaches to cost containment often pits competitive strategies against regulatory approaches. I have found it more useful to approach this question by considering the various components of expenditure increases. Basically, expenditure increases are the product of price increases, demographic change, and increases in services per capita. Policies can be directed at two of these components: prices and volume of services per capita.

Components of Expenditure Increases

Physician fees have long increased far more rapidly than general inflation. This has continued despite substantial increases in physician supply and success by large payers in obtaining discounts. Economists have been hard pressed to explain the phenomenon as the outcome of normal market forces.

Demographic change tends to play a smaller role than many imagine. Population increases at about 1 percent per year in the United States. One economist has estimated that aging of the population will contribute 0.5 percent per year growth in the quantity of health care services.¹

Changes in medical practice are probably the most important source of expenditure increases. In the Medicare program, for example, physicians' services per age-adjusted enrollee increased at an average annual rate of 7.4 percent over the 1986-1989 period. Changes in medical practice reflect developments in technology, increases in physician supply and specialization, defensive medicine, and other factors.

Policies to Limit Prices

Price can be constrained by more aggressive purchasing on the part of payers or government regulation of prices. The research literature provides little support for the notion that prices can be constrained if individual patients have greater incentives to shop for lower prices.

Some large private purchasers have obtained discounts from providers by offering financial incentives to plan members to use those providers agreeing to the discount. Such mechanisms range from the health maintenance organization (HMO), where care outside of the network of providers is not covered, to the preferred provider organization (PPO), where services are covered but at higher cost sharing.

¹ Fuchs, Victor R., "The Health Sector's Share of the Gross National Product," *Science* 247:534-538, February 2, 1990.

While some purchasers have saved money in this way, the potential saving is limited for a number of reasons. First, significant administrative costs are involved in setting up these networks. Second, the financial inducements to patients (lower cost sharing when the preferred providers are used) are often costly to payers. Third, providers may often be able to offset a portion of the discounts by raising fees to other purchasers and/or increasing service volume. Finally, the impact on trends in price growth, as opposed to levels, is uncertain.

Medicare has saved money by purchasing physicians' services aggressively. Since 1984, Medicare has substantially constrained its rates in relation to what physicians charge private patients. With accompanying limits on what physicians can charge Medicare patients, the program has precluded recoupment of these cuts by charging patients more. While some of these cuts may have been offset by changes in volume of services, volume did not grow more rapidly during this period than in the preceding period.

What is not clear is how much additional constraint can be applied by Medicare without a resulting reduction in access to care by beneficiaries. Physicians speak increasingly of the incentives they face to favor privately insured patients. In Medicaid, a program that accounts for a smaller proportion of physician services and has much lower payment rates than Medicare, low rates clearly have limited access to mainstream care. In a recent study initiated by this Subcommittee, the Commission found Medicaid rates to average 64 percent of Medicare rates and physician participation to be a substantial problem in many states.² The Medicaid experience points out the limitations of policies to constrain prices that are conducted by individual payers.

Containing costs by limiting prices could be pursued more vigorously through an all-payer rate setting mechanism, such as the one specified in your proposal, H.R. 2535. Many foreign health systems have contained physician service costs through constraint on prices by either a single payer (for example, Canada) or for multiple payers acting in a coordinated fashion, as in Germany. In the Commission's 1991 Annual Report to Congress, a chapter is devoted to illustrating how the Medicare Fee Schedule could be applied more broadly in the United States and identifying the design issues that would have to be addressed.

Policies to Limit Volume of Services

Containing costs by limiting the volume of services can be approached through a wide range of options. Financial incentives can be directed to patients (cost sharing) and/or providers (units of payment other than fee for service). Administrative controls can be used to limit the use of certain services. Physicians can be provided with additional information on appropriateness. Constraints can be placed on the proliferation of new technology. Tort liability can be revised.

² Physician Payment Review Commission, *Physician Payment under Medicaid*, Report to Congress No. 91-4, July 1991.

While increased use of cost sharing can reduce the volume of services, few are eager to make much more extensive use of it. Research has shown that consumers have difficulty in distinguishing between important and unimportant services when reducing volume in response to cost sharing.³ Despite cost sharing's theoretical virtue of having prices reflect the resources involved, consumers would rather not face stiff financial barriers to the use of care when it is needed. Medicare beneficiaries pay substantial premiums for Medigap coverage to reduce the degree of cost sharing faced when care is needed.

Health Maintenance Organizations (HMOs) have experimented with various financial incentives for physicians, such as capitation for primary care and placing physicians at partial risk for the costs of hospital admissions and specialist referrals. Little research is available on the effects of such incentives. Many believe, however, that the absence of fee-for-service incentives to provide additional services in traditional group and staff model HMOs plays a significant role in the documented savings in those organizations. Some have concerns that in less structured settings, strong provider incentives to reduce service use could limit appropriate as well as inappropriate services.

Use of administrative controls on utilization has increased substantially during the 1980s. Most private payers require prior approval of hospital admissions and major outpatient procedures and make advance determinations of appropriate lengths of stay. Research suggests that some of these efforts have been effective, though the costs of administration offset some of the gains and some of the reductions in service use become additional responsibilities of the patient's family. The effects on rates of service use by patients covered by other payers has not been examined. With improvements in data and more consensus on appropriate patterns of practice, administrative controls may become more effective over time.

A significant cost of administrative controls is physician loss of clinical autonomy. When compared to their counterparts in other advanced nations, American physicians face a substantial degree of review of their clinical decision making. Physicians have complained loudly to Congress and to state legislatures about the "hassle factor". They must consider whether to seek to follow their foreign counterparts in sacrificing some economic freedom to protect their clinical autonomy.

Interest in practice guidelines and effectiveness research is based on the premise that physicians can practice in a more cost-effective manner if they have better information. The leadership of the medical profession has embraced efforts to work with the federal government to develop and disseminate this information. It will be some time before an assessment can be made of the impact of these efforts on aggregate costs.

Notions that better information can improve medical practice lie behind some of the newest experiments in managed care. Rather than service-by-service utilization review and financial

³ M.F. Shapiro, J.E. Ware, and C.D. Sherbourne, "Effects of Cost Sharing on Seeking Care for Serious and Minor Symptoms: Results from a Randomized Controlled Trial," *Annals of Internal Medicine*, 104 (1986), pp. 246-251.

incentives to individual physicians, some physician networks emphasize profiling of physicians and feedback of information to motivate more effective practice patterns. While evaluative research is not available, some major employers are highly enthusiastic about the potential of this approach and have made this the centerpiece of their cost containment strategy.

A consideration in the Commission's development of its proposal that led to the Volume Performance Standard mechanism is that broad economic incentives to the profession could help stimulate activities on the part of the profession to increase the appropriateness of medical practice. Under VPS, a goal for an acceptable rate of increase in expenditures is set and future fee updates are based on the degree of success in meeting that goal. This linkage between expenditure growth and fee increases provides the incentive to physicians collectively. The activities that VPS could stimulate include both the development of meaningful practice guidelines and education of practitioners whose practice patterns deviate from patterns of appropriate practice.

Many believe that rapid adoption and dissemination of new technologies for which effectiveness has not been assessed contributes to rising costs. While foreign health systems have relied heavily on control over the dissemination of new technologies, attempts to do this in the United States through certificate-of-need regulation have not achieved substantial success. Some question whether the American political system can effectively perform this particular type of regulation without capital budgeting by government.

Some assert that reform of the malpractice system is critical to physicians being able to practice cost-effective medicine. It has been very difficult to quantify the magnitude of defensive medicine, though the Congress has recently asked the Office of Technology Assessment to conduct a major study. Many physicians have asserted that malpractice risks could limit the effectiveness of many policy initiatives to constrain the volume of services. While a number of states have implemented tort reforms, such as limitations on the size of awards, additional options, such as use of administrative mechanisms in place of judicial proceedings and various types of "no-fault" mechanisms need to be considered.

COST CONTAINMENT UNDER HEALTH CARE REFORM

While some cost containment policies have been successful, at least at the level of the individual payer, little effect is seen at the system level. Despite the introduction or intensification of many cost containment activities during the latter half of the 1980s, no slowdown in national health spending has been perceived. Analysis by the CBO shows the rate of increase in real national health expenditures per capita to have been 4.3 percent per year between 1980 and 1985 but 4.6 percent per year between 1985 and 1989.⁴ It is possible that the fragmented nature of attempts to contain costs has led to gains in some areas being offset by losses elsewhere. Alternatively, achievements of cost containment policies could have been offset by unrelated factors, such as an acceleration of the cost-increasing effects of technological change.

⁴ Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991), p. 55.

Health care reform legislation provides the opportunity to pursue cost containment more effectively by coordinating the activities of different payers. In particular, policies to contain costs through the price side can be pursued much more effectively when a mechanism is in place to determine payment rates for all payers in a coordinated fashion. This would preclude the ability on the part of providers to shift reductions in payments from one payer to another and remove the risks of beneficiaries in one program having limited access because that program's payment rates are far lower than those of other programs.

Limitations on charges to private payers plays a prominent role in a number of the major pieces of health care reform legislation that continue private insurance, such as H.R. 2535 and Mr. Rostenkowski's proposal, H.R. 3205. These proposals take very different approaches to setting the payment rates. Under H.R. 2535, private payers would have the option of paying at Medicare rates, which would continue to be set as under current law. Under H.R. 3205, rates would have to be consistent with a national cap on expenditures tied to gross national product. A commission would allocate expenditures among classes of providers and review rates set by HHS to ensure consistency with these decisions. Given the potential of all-payer mechanisms to limit price increases more effectively than past efforts by individual payers, these proposals have made an important contribution to the coming debate on cost containment.

All-payer mechanisms may also provide opportunities to pursue cost containment on the volume side. For example, the database needed to administer such a system would provide payers with the ability to profile medical practices, thus permitting them to substitute this less-intrusive manner of utilization review for service-by-service examination.

Much of the focus of debates on the merits of all-payer mechanisms centers around whether they would preclude competition among private plans on the basis of the effectiveness of managing care. When the Commission discussed this issue in its 1991 Annual Report, it emphasized that compatibility with competitive approaches depended on the specific design of the all-payer mechanism. The mechanism proposed in H.R. 2535 appears to be particularly compatible with the potential of a competitive sector. It permits private payers to pay at different rates from the public program if they choose to and explicitly states that the payment mechanism does not preclude HMOs from negotiating rates of payment with providers.

CONCLUSION

The Commission is just beginning its work on the relationship between Medicare policies and employer attempts to contain costs. Its initial efforts have focused on the use of elements of the Medicare Fee Schedule by private purchasers, both on a voluntary basis and as part of an all-payer system. To build on last year's work of identifying design issues for an all-payer system, the Commission has begun to delve into the data requirements to administer such a system. This has proved to be a fruitful area to date, since such a database would have many additional applications dealing with cost containment and quality of care. The Commission will be discussing further activities in this area and has been holding discussions with Congressional staff concerning priorities.

Mr. WAXMAN. Thank you.
Dr. Herdman.

STATEMENT OF ROGER C. HERDMAN

Mr. HERDMAN. Thank you, Mr. Chairman.

OTA is pleased to appear before you on the subject of health technology and cost control, which you requested we testify on. My remarks are submitted to the record. I am going to try to summarize them very briefly.

Based on our experience looking at health technologies over the last 17 years for this committee and for other committees of Congress, we have learned and reported to you and to other committees that health care policy influences the patterns of diffusion and use of health technology and those patterns influence health care costs and outcomes in a very significant way, so that health technology is a major factor to be considered in any effort at reforming the health care system.

Reform itself poses the challenge of achieving universal access to effective health care at a cost acceptable to the American people, we believe. And as you noted earlier in some of your remarks to Mr. Kirkland, tradeoffs will certainly be required. We will not get access to all the technology that is possible, or may even be desirable, without considering costs and trading off between those two factors.

Over the years, we have come to the conclusion that 20 to 25 percent of the annual increases in costs in the health care system are due to health technology, the introduction of new technologies, greater use of existing technologies, or a richer mix of technologies applied to health conditions. And as we look at international comparisons, we see that the United States does not have more doctors in other countries, does not indulge in more doctor visits than other countries. These are comparable industrialized countries. It hasn't had more hospitals, more hospital beds, or more hospital days. But what it does have is more specialists, and more expensive hospital days. Which makes us wonder if maybe technology is not built into the base in a very substantial way and explains some of the major differences that were pointed out earlier in the costs of health care in this country as compared to other industrialized nations.

We think these are all important issues, and OTA is pleased to be a part of Congress's examination of health care reform and changes in the system to improve it and extend it.

As far as international health technology is concerned, we will be doing a study on international costs and health technologic use in various industrialized countries. Whether defensive medicine is an issue that explains some of these differences is another aspect that we will be looking into.

We are also studying health insurance and the use of technology, the impact that health insurance has on the locus of care and on health outcomes for people who do or do not have insurance or are underinsured. The Energy and Commerce Committee, if I am not mistaken, is a requester of all three of these studies.

In my testimony, I have presented some things to think about when you do look at technologies in reforming the health care system. Let me just go through some of these to give a sense of some of the issues which we think need attention.

Some technologies are characterized by great expense, \$350,000 a year for this technology, every year. And, absent special intervention, by absolute variation in access depending on financing status. The pharmaceutical Ceredase for Gaucher's disease is such an example.

Second, accurate data should be used to develop clinical or public health guidelines, care should be used to insure that guidelines will have the desired effects, and costs should be considered when developing guidelines because they can have great financial considerations. Cholesterol screening is a prime example of this consideration.

Third, as shown by the case of home parenteral therapy, care is needed concerning the effect of new insurance coverage on expanding the development, dissemination, and use of new technologies, and as you know, we are submitting a report on this matter very shortly to the Congress.

Fourth, factors other than assessment and scientific data influence technology use. Defensive medicine is a powerful factor in such use, and can be a deterrent to subsequent rational modifications in clinical practice, as shown by the case of electronic fetal monitoring.

Fifth, there is a direct relationship between the supply of technology and the pricing of that technology, and there are dangers in rewarding oversupply with inefficient pricing, as illustrated by extracorporeal shock wave lithotripsy, and more recently we testified in the Ways and Means Committee on the same subject, in respect to screening mammographic machines in this country.

Finally, pricing affects the effective use of technology and the quality of care. And Medicare payment policy exerts a powerful influence on the diffusion, use, and cost of technology, as shown by the recent example of recombinant human erythropoietin, a drug that reduces the need for blood transfusions by correcting anemia associated with renal failure.

Let me turn now to the conclusions which are in our testimony and just cite them. The payment systems that bundle services together or in aggregate caps will on the whole produce better technology decisions than will those that control the prices or use of individual services. I would note that bundled payment usually rewards the provider for doing less rather than more, beneficial new technologies that raise costs will be discouraged except where they provide competition for patients.

Health system reform should promote the effective use of technology but also allow for introduction of technological advances, one of the rationales, I think, for the creation of the Prospective Payment Assessment Commission, which Dr. Altman might comment on subsequently.

Second, information on technology's effectiveness and cost effectiveness is essential for proper decisions on technology use under a cap. I would note to meet the public's demand for cost contain-

ment, we must address the important questions of medical practices that are not clearly ineffective, but may not be cost effective.

That ends my testimony, Mr. Chairman.

[Testimony resumes on p. 303.]

[The prepared statement of Dr. Herdman follows:]

Statement of

Roger C. Herdman, M.D.
Assistant Director for
Health and Life Sciences

Thank you, Mr. Chairman. I am Roger Herdman, Assistant Director for Health and Life Sciences, at the Office of Technology Assessment. I am here at your request to offer testimony on issues of health care technology¹ raised by the prospect of health reform. In response to requests from this and other Congressional committees, OTA is currently conducting or planning three major studies that we hope will further expand the knowledge base in this area: a study of the impact of insurance status on the use of technology; a study of defensive medicine practices and how they influence use of technologies; and an international comparison of medical technology use and its impact on health care costs and health status outcomes. As Congress proceeds in its efforts to find a solution to our growing triple problems of access, cost and quality, we hope to provide the committee with specific help on technology issues. My testimony today, though, is based on OTA's cumulative experience over the past 17 years in examining the impact of health care policy on patterns of diffusion and use of medical technologies and in turn how such patterns influence health care costs and outcomes. In short, how technology finds itself a major vehicle through which policy influences health care and thus is a factor that needs to be considered in reform.

Health Reform

Health reform means making tradeoffs between access to high quality care and the cost of providing that care. Anyone who tells you that that tradeoff is not required, given today's state of knowledge, is not facing reality. The challenge of

¹ OTA defines medical technology as the drugs, devices, and medical and surgical procedures used in medical care, and the organizational and support systems within which such care is provided.

health reform is how to provide universal access to effective health care at a cost that is acceptable to the American people. The rapid advance of medical technologies in the past two decades adds special urgency to this challenge. As effective new technologies are developed to diagnose, treat or even prevent life-threatening illnesses, differences among segments of the population in access to these technologies will become less and less acceptable. The evidence seems to suggest that people without financial access to care, or those covered under programs for the poor (i.e., Medicaid), are often treated less intensively than are those who, by reason of income or insurance, have the resources to afford virtually all of their health care needs. In a recent study of hospital patients, the uninsured were 29 to 75 percent less likely to be given each of five high cost inpatient procedures, including coronary artery bypass graft, total knee replacement, total hip replacement, stapedectomy, and surgical correction of strabismus (Hadley, 1991). The Hadley study also found other indications that uninsured people were treated significantly less aggressively, had shorter lengths of stay, and in general were the focus of lower resource use in the hospital. Similarly, a study of patients admitted to Massachusetts hospitals in 1985 with circulatory disorders or chest pain, showed that Medicaid patients had a much lower rate of use (than private patients) of angiography, angioplasty, and bypass grafting procedures (Wenneker, 1990). An additional and particularly disturbing finding was that Medicaid patients were found to have even lower utilization rates of these procedures than uninsured patients. While lower utilization is not necessarily synonymous with less effective care, it seems reasonable that these data reflect differences in access which do translate to less satisfactory outcomes.

In contributing to escalation of health care costs, some new technologies actually increase problems of access, as more and more Americans cannot afford the health insurance so necessary to pay for these services. Thus, the proliferation of new technologies presents an imperative to provide access at the same time that it makes access more difficult to provide.

Technology and Health Care Costs

Analysts have gone round and round for years attempting to estimate the contribution of medical technology to increases in health care expenditures. Between 1980 and 1989, per-capita personal health care expenditures increased by 122 percent, from \$928 to \$2,068 (Lazenby and Letsch, 1990). Only 39 percent of that increase can be laid at the door of general price inflation. The rest is due to changes in the amount and mix of services offered (42 percent of the increase) and to rises in health care prices that exceed price inflation (20 percent of the spending increase).²

Changing demographics and disease patterns may explain some of the changes in the mix of services -- certainly the aging of the population has some effect on the use of technology, and the emergence of AIDS as a major lethal disease has required more expenditures³ -- but how much of the increase is due to these and other external factors affecting the demand for health care, and how much is due simply to the introduction of new technologies, or to increases in the prices of existing technologies, or to increasingly frequent use of existing

² These are rough estimates, because price indexes for medical services do not completely account for changes in the mix of services offered.

³ In 1987 OTA estimated that the direct costs of treating AIDS could reach \$7 billion by 1991. (OTA, "The Costs of AIDS and other HIV Infections: Review of the Estimates, Staff Paper, May, 1987, p. 3).

technologies has not been estimated. Our best guess, based on our own work and a review of more recent studies is that over the past 15 years, increasing service intensity -- the use of more services or changes in the mix of services to those of greater complexity and cost -- is responsible for roughly 20-25 percent of the total increase in per-capita health care expenditures (OTA, 1984; Lazenby and Letsch, 1990). Remember, too, that increasing medical prices are partly a technology problem -- if over time we are paying more (relative to general price inflation) for the same drug, device, or medical procedure, then the technology becomes less accessible to those who cannot pay and more costly for those who do. So, part of the excess medical price inflation can be considered a cost of medical technology.

What does all this tell us? It says that the choices we make individually as patients or providers and collectively as insurers or governments about the technologies we buy and the prices we pay for them contribute significantly to the cost-escalation problem. Any attempt to moderate increases in the real cost of health care will involve changes in the way those choices are made.

There is another side to the story, of course. As a society we value and demand improvements in medical technologies and their promise for a longer or better life. Innovation in medicine depends on the ability of those who will incur the costs and risks of development to anticipate sufficient returns. Health care policies, including financing, payment, subsidies and regulations, offer opportunities and barriers to realizing returns to innovation. Any cost-containment strategy that sets up hurdles for a new medical technology to overcome will alter its stream of returns to its developers and send signals of uncertainty about future returns from today's investment in R&D. One challenge for cost-containment

under health reform is to devise methods that will encourage and enable providers and patients to adopt and use medical technologies that are effective but discourage both the adoption of medical technologies that offer little or no additional benefit and the use of effective technologies in marginal indications.

Substantial evidence, both from OTA's work and from others, has confirmed the exquisite sensitivity of technology adoption and use to the economic incentives facing developers and providers. (OTA, Medical Technology and Costs of the Medicare Program, 1984; OTA, Federal Policies and the Medical Devices Industry, 1984; OTA, PPS, 1986; OTA, Payment for Physician Services, 1986) The evidence is on both sides -- some technologies are "orphans" in that they do not diffuse despite the promise of medical benefit because payment or regulatory barriers render them poor economic risks. Many other technologies, which may be very useful for some indications, are widely used in marginal situations because insurers will pay for them. In addition to payment, regulation of the introduction of new medical products, the medical liability system, and utilization controls affect the profile of costs and returns to any innovation. This amalgam of forces operates at the micro-level and affects each technology differently.

Findings and Case Studies

In an addendum to this testimony, which I also submit for the record, I present examples, in the form of case studies of specific health technologies, illustrating a series of findings about medical technology and health policies. These findings, and their illustrative cases, are:

- Some technologies are characterized by great expense and, absent special intervention, by absolute variation in access depending on financing status. The pharmaceutical CEREDASE for Gaucher's disease is such an example.
- Accurate data should be used to develop clinical or public health guidelines, care should be used to ensure that guidelines will have the desired effects, and cost should be considered when developing guidelines because they can have great financial implications. CHOLESTEROL SCREENING illustrates this finding.
- As shown by the case of HOME PARENTERAL THERAPY, careful consideration is needed concerning the effect of new insurance coverage on expanding the development, dissemination, and use of new technologies.
- Factors other than assessment and scientific data influence technology use. Defensive medicine is a powerful factor in such use, and can be a deterrent to subsequent rational modifications in clinical practice, as shown by the case of ELECTRONIC FETAL MONITORING.
- There is a direct relationship between the supply of technology and the pricing of that technology, and there are dangers in rewarding oversupply with inefficient pricing, as illustrated by EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY.

- Pricing affects the effective use of technology and the quality of care, and Medicare payment policy exerts a powerful influence on the diffusion, use, and cost of technology, as shown by the recent example of RECOMBINANT HUMAN ERYTHROPOIETIN, a drug that reduces the need for blood transfusions by correcting anemia associated with renal failure.

Though it is very easy to document how sensitive technology decisions are to health care policies, as the examples above illustrate, it is often very difficult to determine whether the effect is, on balance, good or bad. The judgment that medical technologies are overused presupposes standards of appropriate use based on information about the outcomes and effectiveness of the technologies. For some technologies, however, there is no generally accepted standard of appropriate use, and little or no information is available about outcomes or effectiveness on which such standards could be based. As a result, claims that the technologies are overused or, for that matter, under used or inappropriately used, cannot be rationally evaluated.

It is frequently said, for example, that life-sustaining medical technologies, such as mechanical ventilation and tube feeding, are overused for elderly people. In a 1987 study of five life-sustaining medical technologies, including these two, OTA found that there was virtually no information about the outcomes or effectiveness of the technologies for elderly people and therefore that there was no rational basis for determining whether the technologies were or were not being overused. (OTA, 1987) In the case of life-sustaining and other medical

technologies, there may be disagreement about what constitutes effectiveness, but the general point is clear--that without information about outcomes and effectiveness, one cannot determine whether a technology is being appropriately used.

Conclusions and Implications for Health Reform

As Congress deliberates approaches to health reform, the lessons of the past regarding medical technology suggest, in OTA's view, two conclusions:

1. Though there is no perfect system for allocating health care dollars, payment systems that bundle services together and set aggregate caps will, on the whole, produce better technology decisions than will those that control the prices or use of individual services. (OTA, Medicare's Prospective Payment System, 1986) Health system reform should promote the effective use of technology and also allow for innovation and introduction of technological advances.

Payment bundles offer the following advantages: they encourage providers to make rational tradeoffs among alternative technologies; they allow providers and patients flexibility to alter decisions to fit individual circumstances; and they make new technologies meet a test of cost-effectiveness relative to existing technologies.

Medicare's DRG hospital payment system, the classic example of bundled payment at work, demonstrates the power of payment bundling to alter decisions about the adoption and use of medical technologies.

Bundled payment creates new medical technology problems even as it solves old ones. The most serious problem is that such global payment systems may be unresponsive to technological change over time. Providers should be encouraged to adapt to appropriate new technologies. If the payment system remains rigid in the face of medical progress, it will gradually become unacceptable. Yet, it is not easy to adjust payment rates to new economic or technological conditions without having the system gradually revert to fee-for-service payment. Since bundled payment usually rewards the provider for doing less rather than more, the adoption of beneficial new technologies that raise costs will be discouraged, except to the extent that competition for patients induces providers to offer new services. Not only must the health care system be competitive for bundled payment to work well, but consumers must be able to assess differences in the quality of alternative providers. OTA's work in this area suggests that valid indicators of quality of care are not presently available to consumers (OTA, *The Quality of Medical Care*, 1988). This leads to our second conclusion:

2. Information on technologies' effectiveness and cost-effectiveness is essential for proper decisions on technology use under a cap.

The problem of evaluative information is not new. In 1980, OTA's study of the Implications of Cost-Effectiveness Analysis of Medical Technology documented the lack of good information about both the costs and effects of many commonly used medical technologies as well as the failure of the health care system to incorporate

what information was available into the practice of medical care (OTA, 1980). In the past few years, concern about the perceived overuse and inappropriate use of some medical technologies, the lack of information about the effectiveness of many medical technologies, and the lack of standards for their use has spurred increased interest in technology assessment, outcomes research, effectiveness analysis, and practice guidelines. The recent creation of the Agency for Health Care Policy and Research is a manifestation of our increasing awareness of the importance of good information. In addition to its new responsibility and funding to engage in technology assessment, outcomes research, and effectiveness analysis is a legislative mandate to develop and disseminate clinical guidelines.

Although the law does not specify that the clinical guidelines developed by AHCPR consider health care costs as well as effectiveness, Congress clearly expects that the process will not only improve the quality of medical care but will also reduce health care costs. AHCPR is currently developing its first set of guidelines under its new authority, and the process will undoubtedly evolve over time. Of particular concern is that the guideline panels of these early efforts do not include any members representing groups, such as employers or health insurers, with a direct interest in cost containment. Most panel members are subspecialty physicians with expertise in the clinical areas pertinent to the technologies and diseases under evaluation (Garber and Wagner, 1991).

Ultimately, information must be provided both on costs and effectiveness, and the structure of our health care payment system must reflect the tradeoff between the two. The overall magnitude of clearly ineffective care, versus care that is of uncertain or untested effectiveness or of marginal effectiveness, is likely to be small (Garber and Wagner, 1991). A recent study of the appropriateness of

coronary artery bypass surgery in three hospitals found that 14 percent of the operations were performed for inappropriate reasons, but more than twice as many were performed for equivocal reasons. To meet the public's demand for cost containment, guidelines developers must ultimately address the more important questions of medical practices that are not clearly ineffective but may not be cost-effective. Then, the health care system must be ready, and have the proper incentives, to act on such information and guidelines.

Addendum to Testimony of Roger Herdman**Illustrative Cases of Health Technologies
and Issues in Health Policy****CEREDASE - SOME TECHNOLOGIES ARE CHARACTERIZED BY GREAT EXPENSE
AND, ABSENT SPECIAL INTERVENTION, BY ABSOLUTE VARIATION IN ACCESS
DEPENDING ON FINANCING STATUS**

Gaucher's disease is an inherited metabolic disorder that affects approximately 30,000 people in the United States (Goldman et al., 1991). Victims of the disease lack an enzyme necessary to process a certain kind of fat; as a result the fat accumulates in the body, clogging the liver, spleen, and bone marrow. Onset of the disease in the first 12 months of life or the early years of childhood -- the most severe forms of the disease -- is also associated with central nervous system impairments (such as retardation), limitations of physical growth, delayed onset of puberty, and impaired dentition.

Ceredase, a new drug, gradually rids the body of accumulated fat and alleviates the anemia, organ enlargement, and bone pain associated with the disease. Because the drug does not cure the underlying cause of the disease, it must be given at regular intervals over the lifetime of the individual if its benefits are to remain in effect. Current estimates place the annual cost of the drug at

about \$350,000 (Goldman et al., 1991)⁴. The actual cost of Ceredase therapy will be higher than this, however, because the drug must be administered intravenously over a one- to two-hour period in a doctor's office or hospital outpatient facility.

Technically physicians have had the option of prescribing Ceredase for the treatment of Gaucher's disease since April of this year. Given the cost of the drug and ancillary services associated with its use, it is unlikely that all who might benefit from the drug⁵ have begun to receive it. As of June 2, 1991, 100 Gaucher's patients had begun therapy.

The use of Ceredase in general practice has likely been limited by the nature of insurance coverage available to individuals with the disease and the high cost of the therapy. For example, Ceredase has been a covered Medicare benefit since April. HCFA estimates that a maximum of 1000 to 2000 Medicare beneficiaries could potentially benefit from Ceredase for Gaucher's disease (Booth, 1991), but is uncertain how many will actually avail themselves of the therapy in light of the 20 percent copayment provision under Part B. Unless beneficiaries have a generous supplemental policy that will cover all or most of the more than \$70,000 in yearly copayment costs, it is unlikely many will be in a position to begin Ceredase therapy.

⁴Actual dosage and costs vary somewhat with patients' bodyweights. In addition, researchers have some hope that some patients can eventually be maintained at lower doses costing about \$65,000. To date, no patients have received the drug long enough to determine the effectiveness of any lower maintenance dose (Goldman et al., 1991).

⁵Genzyme estimates that only between 5,000 and 6,000 Gaucher's patients will benefit from the drug, although other researchers have estimated the potential population to be 12,000 (Goldman et al., 1991).

A similar situation holds for most private insurance plans. While many private plans cap the maximum out-of-pocket expense an individual must pay each year, many also cap the amount the plan will pay for an individual service during the plan year as well as over the course of a lifetime. Gaucher's sufferers covered under private insurance plans may find they can afford to start Ceredase therapy but can not afford to continue taking the drug once they use up their benefit. The story of Ceredase points out how enormously expensive some technologies can be and how absolutely access will vary depending on financing.

CHOLESTEROL SCREENING -- ACCURATE DATA SHOULD BE USED TO DEVELOP CLINICAL OR PUBLIC HEALTH GUIDELINES, CARE SHOULD BE USED TO ENSURE THAT GUIDELINES WILL HAVE THE DESIRED EFFECTS, AND COST SHOULD BE CONSIDERED WHEN DEVELOPING GUIDELINES BECAUSE THEY CAN HAVE GREAT FINANCIAL IMPLICATIONS

Cholesterol screening and treatment in the United States is a clear example of what can happen when scientists and public policy makers set out to address a national health problem without consideration of the impacts their course of action is likely to have on health costs. After years of investigation, in the laboratory and clinical settings, there is now a substantial body of literature identifying cholesterol as a risk factor for coronary heart disease. There is also substantial evidence that lowering an individual's total cholesterol level will reduce his or her risk for cardiovascular disease.

The National Health Lung and Blood Institute of the National Institutes of Health used this information to structure the National Cholesterol Education Program (NCEP) announced in 1985. Two years later NHLBI released its guidelines for the detection, evaluation, and treatment of high cholesterol levels in adults and initiated a national media campaign to alert the public and health care providers to the importance of cholesterol screening. Public awareness of the links between dietary fat, cholesterol, and heart disease has increased and physicians have become more aggressive in their treatment of elevated cholesterol levels once detected.

Despite the fact the national guidelines for cholesterol screening and treatment recommend a carefully structured and progressive series of interventions (starting with dietary modification and exercise, progressing to the use of bile acid sequestrants, such as cholestyramine and colestipol, if cholesterol levels do not revert to a "safe level" with dietary intervention alone, and moving on to the new generation of lipid lowering agents only if all else fails) based on cholesterol values and the presence of other risk factors (such as age, gender, family history, and personal health status), there has been a dramatic increase in the use of lipid lowering agents in the United States since 1983. Two drugs -- Gemfibrozil and Lovastatin -- account for practically all of this increase. Just one year after its introduction, lovastatin accounted for almost 30 percent of the 12,000,000 prescriptions for cholesterol-lowering agents dispensed in community pharmacies and chain drug stores, making it the leading cholesterol-lowering drug on the US market.

This example clearly shows the ability of the Federal government to influence public awareness and physician practice patterns if it dedicates itself to the task. More importantly, it shows what can happen when broad public policy is

based on limited information. The expert panel that developed the guidelines for the detection and treatment of cholesterol in adults used clinical and epidemiological data on the effectiveness of cholesterol reduction in middle-aged men to structure a program that encompasses the entire adult population in the United States. No consideration was given to the cost of the program. Subsequent studies have shown that the screening and treatment of women, young men, and elderly men account for most of the cost of the program -- despite the fact that these are the very populations for which there is no clear evidence the program is of any value.

Many billions of dollars will be spent each year on the screening and treatment of hypercholesterolemia if all Americans rigorously follow these guidelines without any reasonable expectation of any concomitant change in cardiovascular disease, overall mortality, or life expectancy (Garber and Wagner, 1991). Even if the treatment of high cholesterol levels in these groups is ultimately shown to be beneficial, studies have also shown that treatment in these groups is not likely to provide enough medical benefits to outweigh the costs and reductions in quality of life associated with diet or drug therapy (Krahn et al., 1991). This situation raises questions about how and by whom national practice standards should be developed.

The last lesson to be learned from the National Cholesterol Program is the limitations of guidelines. If the provider community followed the guidelines to the letter, it would be reasonable to expect a much different use pattern among the lipid-lowering agents now on the market. Given the difficulty of changing lifelong dietary patterns and the unpleasant nature of some of the therapeutic agents, not to mention the side-effects associated with their use, consumer preference is most

likely a primary factor in the high use of lipid lowering agents in the United States, especially the selection of the two therapeutic agents that now dominate the market. But, consumer preference is unlikely the only factor at play here, and points to the fact that we do not know nearly enough about the factors influencing physician practice patterns to rely solely on guidelines to get the job done.

HOME PARENTERAL THERAPY -- CAREFUL CONSIDERATION IS NEEDED
CONCERNING THE EFFECT OF NEW INSURANCE COVERAGE ON EXPANDING
THE DEVELOPMENT, DISSEMINATION, AND USE OF NEW TECHNOLOGIES

An ongoing OTA study on parenteral drug therapies suggests that insurance coverage has affected both the development of, and access to, new technologies to deliver these therapies. Home parenteral drug therapy is a mode of treatment preferred by many patients with an increasingly wide range of conditions including bone infections, AIDS-related conditions, and cancer. The extension of Medicare coverage in 1977 for one of these therapies, total parenteral nutrition (TPN), was a major driving force behind the recent substantial growth of the home infusion therapy industry. Since that time, the industry has succeeded in obtaining coverage for a wide range of therapies from many private insurers--and from some State Medicaid programs--by claiming that home therapy is less costly than its traditional alternative, inpatient hospital care.

The home parenteral therapy technology explosion, however, has made this mode of delivery far more costly than it was a decade ago. To date, providers have been able to charge anything short of equivalent in-hospital care and still gain

generous reimbursement (most frequently charge-based) from both private and public insurers. For example, one provider estimated average monthly charges to be \$14,600 for TPN, \$9,400 for anti-infective therapy, \$2,500 for pain management, and \$1,900 for hydration therapy (anonymous, data provided to OTA, 1991). Advances in vascular access device (i.e., catheter) technology, the development of sophisticated programmable infusion pumps and the increasing complexity and severity of illness in patients who are cared for in the home have all contributed to the increase in cost to the health care system.

While coverage has improved for patients with private insurance, many elderly patients who stand to benefit from the appropriate use of these technologies have limited access due to lack of coverage under Medicare. Current Medicare coverage for the drugs, equipment, supplies, and professional services needed to deliver these therapies is piecemeal and highly inconsistent among the program's fiscal intermediaries and carriers, who are given wide discretion in specific coverage decisions. An OTA survey of all 44 Medicare Part B carriers found that 18 carriers covered antibiotic therapies delivered via an infusion pump, and that specific therapies and conditions covered varied among these 18 (OTA survey data, 1991). Preliminary findings of OTA suggest that home infusion companies, while dependent on Medicare for the better part of any TPN revenues, provide few other forms of parenteral therapy (e.g., antibiotics) to Medicare patients. Of Medicare beneficiaries who do receive parenteral therapies other than TPN in the home, most appear to have private insurance coverage in addition to Medicare.

**ELECTRONIC FETAL MONITORING -- FACTORS OTHER THAN ASSESSMENT
AND SCIENTIFIC DATA INFLUENCE TECHNOLOGY USE. DEFENSIVE MEDICINE IS
A POWERFUL FACTOR IN SUCH USE, AND CAN BE A DETERRENT TO
SUBSEQUENT RATIONAL MODIFICATIONS IN CLINICAL PRACTICE**

Electronic fetal monitoring (EFM) technology emerged during the 1960s and was disseminated widely in the 1970s and 1980s as a means of monitoring a fetus continually during labor to determine its well-being and to detect possible signs of fetal distress (e.g., asphyxia). By the time the first formal assessment of the effectiveness of this technology was published, EFM was already being used in nearly half of all deliveries in the United States (IOM, Vol. II, 1989). Since that time, at least 9 randomized, controlled studies of the effectiveness of EFM in preventing negative birth outcomes have been reported (Neutra et al., 1978; Haverkamp et al., 1976; Renou et al., 1976; Kelso et al., 1978; Wood et al., 1981; MacDonald et al., 1985; Leveno et al., 1986; Luthy et al., 1987; Shy, et al., 1990). None of these studies found significant differences in either perinatal mortality or neurologic outcomes of infants whose intrapartum heart rates were monitored with EFM compared to those monitored by periodic auscultation (use of specialized stethoscope or doppler device to detect the fetal heartbeat) (IOM, Vol. II, 1989; Shy, et al., 1990).

EFM is an example of the limited influence of formal technology assessment on the use of technologies that have already become an established mode of clinical practice. Despite both poor evidence of EFM's clinical effectiveness and the subsequent modification of professional practice guidelines which now recommend periodic auscultation as an equally acceptable method of fetal

monitoring for high-risk patients (ACOG, 1989), wide use of EFM has continued (IOM, Vol. II, 1989; Personett, PC, 9/12/91; Rutledge, PC, 9/12/91) presumably in part from concerns about liability to malpractice suits.

It should be noted, however, that costs and availability of nursing staff required to perform periodic auscultation also influence the continued widespread use of EFM in hospitals (Personett, PC, 9/12/91). Even if hospitals and physicians consider periodic auscultation and EFM to be equally effective, they can be expected to choose EFM if it proves less costly overall or if skilled nurses simply are not available to perform the alternative. An additional risk of EFM--both a clinical risk to the patient and a cost risk to the system--is its association with increased cesarean section rates (Placek, 1984). A 1989 study by the Institute of Medicine reported that EFM and cesarean sections associated with its use in the United States may represent annual costs upwards of \$750 million (IOM, Vol. II, 1989).

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY -- THE DIRECT RELATIONSHIP
BETWEEN THE SUPPLY OF TECHNOLOGY AND THE PRICING OF THAT
TECHNOLOGY, AND THE DANGERS OF REWARDING OVERSUPPLY WITH
INEFFICIENT PRICING

Approved by the FDA in December of 1984, extracorporeal shock wave lithotripsy is a technological, non-surgical treatment for kidney and upper ureteral stones.⁶ In terms of cost-effectiveness per patient, ESWL has been shown to be unquestionably superior to surgery for patients with equivalent disease (Hatziafreu, 1990).

Both Medicare and private insurers moved quickly to cover ESWL. While Medicare's payment was relatively low at first, private insurers initially reimbursed at rates nearly equivalent to surgery, encouraging hospitals to purchase the technology (OTA, Effects of Federal Policies on Extracorporeal Shock Wave Lithotripsy, 1986; Power, 1987). Hospitals quickly embraced the technology, which contributed to prestige and pleased physicians and patients by guaranteeing access to an effective and increasingly popular medical device. The result of these positive forces has been the lightning fast diffusion of lithotriptors throughout the country. While 1985 estimates of lithotriptors needed for the US population ranged from 17 to 175⁷, actual diffusion of lithotripsy devices had reached 285 units by the end of 1989 (OTA, Effects of Federal Policies on Extracorporeal Shock

⁶ ESWL uses focused intermittent bursts of shock waves transmitted through a water bath to fragment urinary stones so that they may pass spontaneously.

⁷ The initial estimates are sensitive to initial assumptions of the number of patients eligible for ESWL. (OTA, Effects of Federal Policies on Extracorporeal Shock Wave Lithotripsy, 1986)

Wave Lithotripsy, 1986; Power, 1987). The number has continued to grow, and general marketing by other recently approved manufacturers will likely result in further diffusion.

The actual experience of ESWL units suggests that the technology's rapid diffusion has had several undesirable consequences. Between 1986 and 1988, the overall volume of procedures per ESWL unit declined by 20 to 34 percent (Bloom, 1991). This decline in treatment volume occurred despite greatly expanded treatment criteria, indicating over-capacity. Over the same period, technical fees for the procedure increased by 21 percent, suggesting that hospitals have been forced to raise prices to compensate for high fixed costs and declining patient volume (Bloom, 1991). Thus, despite the initial enthusiasm over its great cost-saving potential,⁸ and its undeniable benefits to patients, ESWL has probably not lowered health care costs overall.

RECOMBINANT HUMAN ERYTHROPOIETIN -- PRICING AFFECTS EFFECTIVE USE OF TECHNOLOGY AND QUALITY OF CARE, AND MEDICARE PAYMENT POLICY EXERTS A POWERFUL INFLUENCE ON THE DIFFUSION, USE, AND COST OF TECHNOLOGY

Recombinant human erythropoietin (EPO) illustrates the powerful influence Medicare payment policy exerts on the diffusion, use, and cost of technology and on the quality and effectiveness of care. Approved by the FDA in June of 1989,

⁸ By replacing surgery, government officials originally predicted that ESWL could save up to \$2000 per patient (OTA, Effects of Federal Policies on Extracorporeal Shock Wave Lithotripsy, 1986)

EPO is an orphan drug that reduces the need for blood transfusions by correcting anemia associated with renal failure (OTA, 1990). Medicare has been the dominant payer for the biologic, since it covers more than 90% of dialysis patients through the End-Stage Renal Disease Program. With its dominant payer leverage, the HCFA was able to use its initial Medicare payment policy to establish a low US price for the biologic compared to other countries. Through December 1990, Medicare paid a fixed rate per treatment up to a dose threshold, giving dialysis facilities a financial incentive to treat a high volume of patients at low doses. Actual experience since 1989 suggests that these incentives encouraged the rapid diffusion of EPO among dialysis patients as well as lower than FDA recommended dose regimens. (Sisk, et al.) Fewer than 45% of patients treated for six months or more corrected their anemia to the target level.

Starting in January of 1991 Medicare has paid facilities on a fee-for-service basis based on the administered dosage of the biologic. This policy threatens quality and costs from the opposite direction by giving facilities financial incentives to administer high doses to all patients, while retaining incentives to treat all possible candidates. Patients anemia has been corrected more completely presumably as a result.

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Mr. WAXMAN. Thank you very much for your testimony.

I am trying to understand that first recommendation, bundling of payment as a way to avoid some of the inefficient use of high-priced technology. Are you envisioning a global budget that would say to a physician or a group of physicians, This is the total amount of money you will have, figure out how to spend it wisely?

Mr. HERDMAN. That could certainly be one. The examples one could cite readily would be the DRG system where you have a bundled payment for a diagnostic group, or the ESRD system. In both these cases, bundling has worked rather well. You bundled the components up, the technologies which are used within that bundle, the decisions on that use, then are decentralized to the local level where they should be, one might argue. And in the case of the ESRD program, as you know, the payment has stayed basically the same for many, many years, and people have been able to continue to deliver those services by manipulating the use of those technologies. And the same is true of the DRG system. I hate to talk about that too much with the expert sitting on my right.

Mr. WAXMAN. If one looks at any kind of comparison of the U.S. system to the Canadian system, it is obvious that we spend a lot more of our health care dollar for more specialized care, higher priced technology. They tend to push toward primary care. And if there is a criticism that you hear the most often of the Canadian system, it is that people don't have access to some of the technology, and that such a system doesn't encourage the development of new technology. Is that an accurate statement?

Mr. HERDMAN. Well, it is certainly true that the technology—people—I have now heard almost every State in the Union make the statement, we have more MRI's than the whole country of Canada. It is true. That doesn't mean that Canadians don't have access to technologies that they need.

The other thing that you often hear is, yes, they don't have access to technologies or care that they need, look, they have long lines. And sometimes they do have lines, but I think if you read the literature carefully—and I ought to say that OTA has not studied this, so I am speaking extemporaneously—but if you read the reports of some of those situations, you have the feeling that the reports that they needed care and they didn't get it may be overblown, that there may be other reasons for the queues besides the lack of technology that was needed.

Mr. WAXMAN. Isn't it accurate to say that we in our system put more of an emphasis on use of technology, development of technology, and quite often it is inefficient, quite often it is more expensive and does not produce better health results?

Mr. HERDMAN. I think that is fair to say.

Mr. WAXMAN. You did say 20 to 25 percent of the—what was it, the increases?

Mr. HERDMAN. Twenty to 25 percent of the annual increases extending back decades have been due to technology, yes.

Mr. WAXMAN. What would you say that figure would be for Canada?

Mr. HERDMAN. I would hesitate to say. I really don't know.

Mr. WAXMAN. When you said a 20 to 25 percent increase, is one to assume that some of that increase or a great part of that increase, perhaps, is due to the inefficient use of technology?

Mr. HERDMAN. I think what you can say, and you should be conservative about this because it is hard to prove, but there are studies, as you know, Mr. Chairman, that examined whether or not the technologies that we have were indicated, what percent were not indicated, and what percent of indications were questionable, and you find figures being discussed, like 15 were not indicated, and another 20 percent or so questionable.

Mr. WAXMAN. Dr. Altman and Dr. Davis, as you know, and you have made mention of the fact that in my proposal I call for publicly set payment rates for hospitals and physicians to be made available for private purchasers.

Congressman Rostenkowski in his bill sets an annual limit on increases in total health spending and establishes a Government spending rate in line with a total limit on spending.

What are your views about how effective these approaches would be and are there alternate approaches you would prefer? Dr. Altman.

Mr. ALTMAN. I think that we have learned a lot with respect to the DRGPPS system, and as Dr. Davis indicated, they are in the early stages of learning how their system, the relative value scale system would work, and they are very promising for use by everyone.

But I think we need to be honest with ourselves, and that is, what we have learned under the PPS system is that just looking at Medicare alone isn't enough, and that we really have not seen the potential of the system in effect yet, because hospitals and doctors have been able to shift off the burdens of these limits onto others.

So I support what you are aiming for, which would be to sort of not only make available but actually require that there be some form of common payment system, and that I would think that many would choose to use the Government system. I do think there is some value in experimentation, so some States may choose to use some others.

The real issue is, how tight should the cap be that is imposed over the system. Mr. Rostenkowski has a plan which would tie it over time directly to the GNP. I think that is a desirable goal.

My view is, though, that we would be better served by allowing some flexibility there, and to have this national expenditure board determine what the appropriate linkage would be, but to make clear to that board that significant deviations from the GNP growth would be taken as not in keeping with the legislation, and that the Congress could come back and make it stick.

That is essentially what the German system is all about. The German system does not have a fixed limit on spending. What it does is that their parliament establishes the rates, and that generates a certain amount of money, and that the groups then negotiate, and if they negotiate a little too full a package, combination of fees and volume, those rates are forced to be kicked up, which means the parliament has to get involved again, and it is at that point that the Government resteps into the issue.

I think that is a desirable system for us to have. So, yes——

Mr. WAXMAN. You would be for uniform rates and a cap that is not very tight, that is being negotiated, refined—

Mr. ALTMAN. I would have a uniform system. It is possible that that uniform system could allow, for example, some difference in rate between, say, what a private patient pays and a Government. But it would be structured within the same system, so you might allow a 5 or 10 percent differential.

As I said, other countries would do that. But I wouldn't allow them to be free floating. Again, I would have them under some limits, but I wouldn't tie those limits too tightly to the GNP, although I think that it is a good discipline to get as close as possible to the growth.

I think we should have individual limits involved as well as imposed limits. Economics tells us that if you don't change the underlying incentives, the pressure cooker is going to blow off the top. So you can't just assume that by placing the limits there and doing nothing else underneath, the system isn't going to work. What I do believe is that discipline will—

Mr. WAXMAN. You believe everything you were taught?

Mr. ALTMAN. No. The question is, do I believe everything I teach. But I do believe that discipline on top will force the incentives to change.

We keep talking about incentives. Everyone now is an economist. The truth of the matter is, these incentives are halfhearted and don't work.

Even those that pressure cooker dial may need to be slightly uncorked, putting it on place will force back a new set of incentives.

Ms. DAVIS. The Physician Payment Review Commission has just begun to explore this issue and has focused on what it would take in the way of data development and administrative systems to enact the time of proposals you have in your proposal or the one in Mr. Rostenkowski's proposal, so the commission doesn't have a position in support of those. So I would like to speak in this case individually in response to your question.

I think the approach in your bill of extending Medicare's payment rates to the private sector is an excellent approach. I would also support bringing the Medicaid program in line with what Medicare does. So I think the notion of taking Medicare's resource base, taking Medicare's DDOG perspective payment system for hospitals and extending that to Medicaid, extending that to the private sector, is very much the way to go. And I would go further than Mr. Altman and support uniform rates, not just a uniform system.

I don't think there is any real rationale for Medicaid paying any less than Medicare, any real rationale for private insurers paying more than Medicare. You may have to phase it over time to get to, that but I don't see the logic of having a variable rate across payers.

In terms of the notion of whether there should be a uniform all-payer payment system, an overall limit on spending, I would very much support that, and I would very much support linking it to something like the rate of growth in the gross national product. If you do, you are talking about allowances for population growth, you are talking about allowance for inflation, you are talking about

allowances for increased technology, improvements in quality of care, additional utilization of services.

We are talking about in typical times a nominal GNP going up 6 or 7 percent a year. You are talking about the slowing of the rate of growth down to 7 percent. But it is not excessively stringent.

I think Mr. Rostenkowski's proposal would phase that and hit that after 7 years rather than immediately, so we will wind up at 13 or 14 percent GNP before that clicks in.

I don't have Mr. Altman's concern that that is too rigid, but what Congress might do is follow the approach it is followed in the Medicare standards. You have a default formula, so you might say, this overall limit will go up with GNP, and that is the formula in the legislation, but every year the Secretary of Health and Human Services, a commission or health expenditure board, could recommend to the Congress whether this year it ought to be a little more, a little less, and Congress could, for an annual budget reconciliation act or other mechanism, differ the perspective expenditure limit from GNP in a given year if there were reasons to do so.

So I think there is a way you could link it by formulating it to the GNP but have a process whereby various parties could bring to bear research on effectiveness needs or new technology. So I think there is a way we could deal with that.

Mr. WAXMAN. It sounds like you would rely more on research on effectiveness of technology rather than the forcing of bundling of payments to be more efficient in sorting out—

Ms. DAVIS. Well, I certainly support the DRG support to payment. It is a flat rate per case. Certainly the Physician Payment Review Commission has supported a global surgical fee that covers preoperative, surgical, and postoperative care in a single fee. So I think there are opportunities for bundling that are appropriate.

If you are to pay a physician a single fee for the care of a hospitalized patient, including the fee for the anesthesiologist, the surgeon, the admitting physician, that then you are probably not going to have a fine enough system to vary with the situation of different patients. So I think there are areas where you could do it.

I personally could support having Health Maintenance Organizations that are paid on a capitated basis as part of our overall system. So I think there are opportunities. But I think the real promise for control is having an all-payer payment system within the context of an overall expenditure limit.

Mr. WAXMAN. Thank you.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Let me thank all of the panelists for excellent presentations, and all of your good work.

Ms. Davis, you have spoken very favorably about the cap concept that Chairman Rostenkowski has in his bill. What I am troubled about, based on what we have today, the prospect that we will reach that cap, that we will say, woe, we are out of money, which is essentially what the cap says, and what we will have bought when we purchase up to that cap, is we won't have bought the most important things in health care, the preventive kind of services, the prenatal services, the kind of most critical benefits, and

what we will have done is spent the bulk of the money on perhaps care that would be much more expensive or marginal.

Are you concerned about that prospect, and what do you think we ought to do with this?

Ms. DAVIS. The level of spending is very high in the United States relative to other countries. I think it is very important, again speaking individually, that a comprehensive health reform bill include an emphasis on prevention, that it should cover preventive services for pregnant women and children.

I think it is very important to encourage primary care, and certainly the resource base relative value schedule does that. It brings up physician payment rates for visits to physicians, reduces payment rates for technological, specialized procedures. So that is a way of sending the right economic signals to encourage those types of services.

I think there are other things that have to be done. I think the effectiveness research, the development of practice guidelines, looking at issues of physician supply, are also important complements to this overall approach.

But again, speaking personally, I am very concerned by proposals that would set priorities for rationed care for the poor, sick, disabled and elderly, and limit care that works to improve health for the quality of life for those patients, when we know we are spending money in the system for high administrative cost, that physician fees in the United States are 2.6 times as high as they are in Canada, when we look at prescription drugs and see the prices being paid for those kinds of services, some of the information in Mr. Herdman's testimony, when we see the waste that is going on in our current system, when we see the use of ineffective and unnecessary services, when we see hospitals with 60 to 65 percent occupancy rates, and each hospital having their own specialized procedures, you think there are a lot of ways in our system to live within 12 percent of GNP, or a lot less, actually, without having to ration care that works to improve health outcomes, the quality of life, and for people who are sick.

Mr. WYDEN. I share your view about all the waste, and I guess my concern is that even if we go after all that waste, with the technology we have got, with the aging population, with these inexorable forces, I am convinced we are going to have to make some choice, and if we just go out and say, we are going to cap it, under the status quo, where you don't make any choices, you say you are going to try and buy the preventive services and you are also going to try to buy acute services as well, the high-intensity services, we are going to run out of money, we are going to hit that cap, and lots of the things that the poor people and the kids need the most that are actually some of the cheapest aren't going to be bought.

Dr. Altman, do you have any reaction to that?

Mr. ALTMAN. I understand what you are saying, but I share Ms. Davis's—it is hard when you look at the numbers to put rationing as the number one cost containment priority. I know what you are saying—

Mr. WYDEN. I don't use the word rationing. You all have been using that word. Other members of this committee use the word ra-

tioning. I don't use that. I use the word "making choices about some priorities."

Mr. WAXMAN. Well, that is rationing.

Mr. WYDEN. It seems to me, and because all of you are so involved in this field, you know that those choices are being made right now, and I am always amazed at how so many who are expert in the field suggest we aren't making judgments about priorities right now. We are making judgments about priorities.

The debate is whether we are going to have a rational way to have a discussion about priorities, or we are just going to continue as we have, which is to lock people off the rolls except when Chairman Waxman can perform another bit of heroism and get some additional money for the poor.

Mr. ALTMAN. I think you have established the debate in a way that I wouldn't establish it, and I think the other panelists wouldn't either. I would not disagree with you at all that we—sure, we have some form of choice decisionmaking, as opposed to rationing, right now, and it is not a good one. But I think what I am proposing, I think Dr. Davis and Dr. Herdman as well are suggesting is that we want to change that. So once you change that and bring everyone into—and having equal access to coverage, access, so that we are not making it the way we are making it today, the next question is, can we do that and leave openended our payment system and our spending? And I am clearly saying no.

Don't get me wrong about that. I am in favor of expenditure limits. I just would like to leave some degree of flexibility for growth now, whether you do it through formulas or whatever.

Mr. WYDEN. There is no quarrel about that.

Let me ask you about one other matter outside the debate over priorities issues we have been talking about. Flesh out for me, Dr. Altman, if you would, the relationship between the expenditure board and outcomes research. How would you take what we know is very promising work in outcomes research and plug into the work of your expenditure board—

Ms. DAVIS. It would be critical. I would hope, and I would make sure that the expenditure board not only have access to this information, but being an important catalyst for what kind of research goes on. I am concerned that these early success stories will filter or fritter away if nobody uses them, and that we will go on to think about other things.

If you have an expenditure board that has to make these decisions, they are going to put a lot of pressure back on the research community to focus their efforts and get their research done. So to me they are critical; the linkage between how much to spend and how to spend it is critical.

Mr. WYDEN. You would see, then, the expenditure board taking the initiative, for example, and trying to direct research in the outcomes area, to try to in effect turn up new ways to come up with effective procedures, based on what you got on the expenditure side?

Mr. ALTMAN. That is exactly right. Their effective use of those dollars are going to require them to decide—now, it isn't so much not to do something. It is also how much to pay for something. And

if we find something is valuable, very valuable, we might want to pay significantly more for it. So, yes, they link very much together.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Kostmayer.

Mr. KOSTMAYER. Thank you, Mr. Chairman.

Mr. Chairman, you asked about technology, the development and the use of new technology. Tell me under what circumstances the development and use of advanced medical technology is a bad thing.

Mr. HERDMAN. It is a horrible thing if the use of the technology is in a situation where it is not medically indicated, where an individual is subjected to a technology without a medical need for it.

Mr. KOSTMAYER. How widespread is that phenomenon in this country?

Mr. HERDMAN. When I responded to the chairman's question earlier, some reports would maintain that that is actually not that uncommon. I was thinking particularly of a study done where the people who conducted the study indicated that with bypass, it was 15 percent just not indicated. That is a pretty heavy burden.

Mr. KOSTMAYER. Fifteen percent of all the bypass in the country may be unnecessary?

Mr. HERDMAN. Were. They said, were.

Mr. KOSTMAYER. Why are doctors performing unnecessary surgery?

Mr. HERDMAN. I suppose for any number of different reasons, and I don't want to say which one outweighs the other. They may be doing it because they feel mistakenly that it is indicated. They may be doing it because they think that they have got to do something because if they don't they will be sued, that—

Mr. KOSTMAYER. Defensive medicine?

Mr. HERDMAN. Defensive medicine. They may be venal, just doing it for money, and so on. I think there are a number of possibilities.

Mr. KOSTMAYER. Dr. Davis, you raised the issues of waste, and also the cost of drugs. These figures that the GAO and others have given the committee, I don't know whether they are figures which can be characterized as waste, excess, administrative—excessive administrative expenditures. Some people call them paper shuffling. Can you bring some clarity to this?

Ms. DAVIS. I think there is evidence of high administrative cost, particularly in private insurance, for example, sold to small businesses. One study, for example, finds that for firms with one to four employees, the administrative cost was those health insurance plans runs 40 percent of benefit outlays, whereas with big firms—

Mr. KOSTMAYER. Why is that?

Ms. DAVIS. A lot of the difference has to do with commissions that are paid to salespeople to sell policies. There are higher profit margins on those policies, higher general claims and administrative expenses of that. Certainly some of the proposals for small group insurance reform would try to deal with some of this by trying to pool that coverage.

Mr. KOSTMAYER. Let me ask what may be a naive question. People who use those health programs are paying that cost, aren't

they? Wouldn't it be in the interest of the people selling these policies to try to bring the cost of their product down so they could sell more of it?

Ms. DAVIS. I think what you are asking is, why doesn't the private market work to eliminate excess profits or improve efficiency in its industry, and we haven't seen that happen.

Mr. KOSTMAYER. Can you tell me why?

Ms. DAVIS. We see competition among firms for the healthy patient.

Mr. KOSTMAYER. I don't know why the market system wouldn't work. The more product you sell, the better off you are, and the less expensive your product is, in this case, an insurance policy, a health care policy, the better off you are.

Why wouldn't someone come in and come to a small business and say, can I sell this very small policy to you for somewhat less, because I pay lower commissions, but in the final analysis, I make more money because I sell more policies?

Ms. DAVIS. Well, it is a judgment on the part of the insurance company that they are better off giving the good commission to that salesperson and having strong marketing techniques than making the policy available at a cheaper cost. But the response on the part of the insurance industry is to find a healthy patient. So they say, find a group where nobody had had a disabled child born or nobody had had a previous stroke or incidence of cancer, or if so will exclude preexisting conditions, we will refuse to write an employee in this firm that has high expenses.

That is the form of competition you see today, to get relatively healthy groups. It has not been a more constructive way as what you would think of, to try to provide a good product at a low price.

Mr. ALTMAN. Let's assume—I think where you are heading is right—that I would say there is no waste and inefficiency and extra administrative cost for these plans. Given the nature of the world out there, the world, the environment that these firms compete in, force them to do a lot of these extra expenses.

When you talk to insurance executives, many of them would like to cut their costs. But they can't, because the environment forces them to be very concerned about getting a sick person. So they spend a lot of money——

Mr. KOSTMAYER. Because if they do get a sick person, the cost to the company——

Mr. ALTMAN. That's right, and they are at risk. So I think—in my own view, we are always looking for the villains. If we can find a villain, we shoot them and solve the problem, it is the simplest way. The new villain is the high cost of insurance.

Don't get me wrong, it is not that I support them one way or the other. I don't think that is the issue. You establish the rules of the game, and I think what I am saying is, you have got to change the rules of game. If you change the rules of the game, you are going to find a different set of incentives.

This is the most heinous and administratively expensive and lacks a sense of compassion that I have ever heard of, and that is where we are going, where you basically ask individuals, as long as you are healthy and wise and rich, you get insurance. If you are

poor and sick and not so wise, you don't get insurance. That is where we are heading.

We now have the capacity, apparently, to sort of look at your blood and figure out whether you are going to be sick 5 or 10 years from now. So you have got to change the rules of the game. If you do that, and I think you ought to change them significantly to wipe out experience rating among small groups, and maybe even wipe it out completely, you would find they wouldn't have to do the things they are doing. I do believe all these separate building procedures add expenses.

Now, on the insurance side and also on the provider side, I think this idea that we give doctors and hospitals money and then we don't trust them one bit, so we go in and we review every case and every procedure is terribly wasteful. Other countries, it is the other way around. We give the hospitals and the doctors a budget and we trust them to do the job, and it is only after the fact if they find absurd behavior do they go in.

So we have become wasteful with our administration, but it is not because the individual companies or hospitals or doctors want to do that, but because they find they have no choice.

Mr. KOSTMAYER. Dr. Davis, you also talked about the cost of drugs, and a couple weeks ago in the Washington Post, there was a story that said, I think, the cost of drugs had gone up about 152 percent over the last decade in this country.

The drug companies defend themselves, by saying a good deal of this money goes into research, which is a good thing, obviously. Who is wrong and who is right here? Are you able to say, or anybody else on the panel?

Ms. DAVIS. In terms of research, those expenses have been netted out before you get to the profit that drug companies are making. Yes, there is an investment in research, and there should be an appropriate incentive to do that.

Mr. KOSTMAYER. These are postresearch net profit.

Ms. DAVIS. Yes.

Mr. KOSTMAYER. Of 152 percent.

Ms. DAVIS. That was the story.

Mr. KOSTMAYER. Is there some justification?

Ms. DAVIS. It would certainly be higher than what an economist would feel is a fair rate of return.

Mr. HERDMAN. I can add, Mr. Kostmayer, we are doing a study on that issue at the request of the chairman. It is a very complicated issue, and I can't tell you—the drug industry would not accept what you just said, as I am sure you well know.

If you wait for 6 months, we will give you the study.

Mr. KOSTMAYER. Do you have any hints? Is it as bad as it looks? I am not trying to be critical of the drug company. I am sure they have an answer.

Mr. HERDMAN. We were asked to look at what the R&D cost of drugs were, and second, whether that justified the pricing policies of the company. It is very hard to tell what the R&D costs of the drugs are. Figures vary from 100 million to as high as 400 million for a drug.

It probably doesn't make any difference what figure you use. Probably you can get almost any figure you want, depending on which accountants you use.

What makes a difference is the question you are asking: Is the profit excessive? And the companies would say they need enormous profits because of the cost of research and development.

Mr. KOSTMAYER. Doesn't it depend whether those profits are going into research? I suppose, to the extent they are going into research, they are right. To the extent they are not being used to research but going to the shareholders—

Mr. HERDMAN. The companies have a record of increasing their financing of research. There is no question about that. Obviously, not all the profits are going into research. Clearly some are going to shareholders.

Mr. KOSTMAYER. People are not going to invest in the companies unless there is a reasonable rate of return.

Mr. HERDMAN. Yes. Believe it or not, it is very difficult to show these companies are as profitable as you say.

Mr. KOSTMAYER. Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kostmayer.

Mr. Richardson.

Mr. RICHARDSON. Thank you, Mr. Chairman. I only have one question. I apologize if it has been asked. Actually, Dr. Altman, Dr. Davis, Dr. Herdman, the malpractice issue. The subject of the hearing is options for controlling the growth in health care expenditures.

I wonder, there are many claims that malpractice is one of the single most active entities driving the cost up. My question is, do you think that in any kind of health care reform, health care expenditures, legislation, cost containment, that we have to deal with malpractice simultaneously, or can we deal with it separately, or do we not need to deal with it?

Maybe I will start with Dr. Davis.

Ms. DAVIS. I would like to ask Mr. Ginsberg from the commission to comment a little bit.

Mr. GINSBERG. Sure. There is no doubt our malpractice system is not serving us well. It is very difficult to estimate the magnitude of defensive medicine, but it is clearly there, and clearly many physicians feel cautious about trying to practice in a more appropriate frugal pattern because of fears of malpractice.

We also know from the perspective of the quality of care, the malpractice system is not doing a very good job in promoting the quality of care. So I think it is clearly an issue that has to be dealt with.

I think whether this is dealt with separately or in conjunction with the health care reform is really more of a political decision, that sometimes policies go well together.

And in this case the attraction is that physicians are very concerned about malpractice. And if this system is improved so they feel under less pressure to be sued for something they think is good medicine, that they may be more willing to go along with other parts of the health care reform.

Mr. RICHARDSON. Dr. Altman.

Mr. ALTMAN. Well, my—I don't think anybody I have ever talked to would not suggest that malpractice reform needs to be an important part of any overall cost containment health reform.

I would oppose that being the only cost containment. I know there are some who would believe if we somehow solved the malpractice problem, we would solve our health care problem.

I find that hard to believe, and I think the evidence doesn't support it. Yes, it very much needs to be part of a reform. No one who has looked at it can come away feeling it is a good system, that it is protecting the people it is supposed to protect, and therefore it needs to be substantially redone.

But as Dr. Ginsberg has pointed out, how to do it is going to be a tricky issue, but it needs to be done, yes.

Mr. RICHARDSON. Dr. Herdman, do you study this issue, too, in your OTA role?

Mr. HERDMAN. Yes, we do. In fact we are starting a major study on defensive medicine at the request of this committee and of other committees of Congress.

I think as Dr. Altman pointed out, there are some members of this House who feel very strongly that the defensive medicine malpractice issue needs to be addressed and resolved as best it can be, coincident with, and would contribute markedly to a health reform, and others are not so sure.

OTA is clearly not going to take a position like that, speaking as a member of your staff, but I would say that it is our view going into this that whatever you think you know about the demographics, the cost, the magnitude, the behavior, whatever, of defensive medicine probably is wrong.

There is not a lot of information, and unfortunately very little good information available, to really make some good policy in this area. I hope we can contribute to that, but I think it will be a difficult task.

Mr. WAXMAN. Thank you, Mr. Richardson.

Let me ask another question that occurs to me.

Dr. Altman, Dr. Davis, you have been talking about major reform, comprehensive reform. Let's say we come to the conclusion, which isn't hard to reach, that we are not going to get major reform in the next year, maybe next 2 years, and perhaps beyond that, especially if we can't get an administration to be engaged on the question.

There are some who are suggesting that let's do what we can do, and they are recommending insurance reform. Senator Benson particularly has introduced legislation along these lines; and Dr. Altman, you suggest we change the rules for insurance. What do you think about just doing that?

Mr. ALTMAN. Well, of course, I think I come out—as you have heard, I do believe we need national and much more substantial reform than what is in Senator Benson's bill, but if you come to the conclusion that that is the best you can do, I think it would be unfair to the millions of people who would be helped by this legislation not to do it.

As you may know, Mr. Chairman, I was part of a serious effort for financial reform in the midseventies, and I saw a lot of people who wanted national reform refuse to go for incremental reform

because they felt they had national reforms in their grasp, and they said no, and then we wound up with doing nothing.

So I think it is ultimately going to be your judgment what can happen, and I surely would not put off these incremental steps as really going to solve our problem, but they will help a lot of people.

Mr. WAXMAN. Will people, in fact, be helped if insurance companies can do some picking and choosing between groups?

The other side of it is, if you really could get a community rating, are we suggesting those who have insurance will pay a higher price for it, meaning many employers might drop the insurance coverage completely since they are not obligated to carry it?

Mr. ALTMAN. Then we get into the specifics of the bill and how to do it. There is incremental reform and incremental reform. I think your questions are very appropriate.

If all you do is community rate among sick and low income people, it will be a nice system, but it will be too expensive for them to buy it.

At a minimum I do believe we should community rate smaller firms. I do think we should do away with individual rating, but I think we need to go further even in incremental reform, and that is get those premiums within reasonable rates, I think as a percentage of income or payroll, ought to be built in.

It would be a real travesty to pass incremental reform and help absolutely nobody, which would be the worst. I think what your questions are leading to, we could find ourselves in that situation.

Mr. WAXMAN. That is what I fear.

Dr. Davis.

Ms. DAVIS. I agree. I think the type of small reform we are talking about won't make a dent in the 34 million people insured, and it won't do anything about the double double-digit cost, double-digit increase we are experiencing.

I don't think we ought to hold hostage coverage for the uninsured, however it can be achieved, waiting for some ultimate solution. I agree with you that if—while it would be very good to prohibit excluding people with poor health histories from coverage with—it would be very good to set limits on—waiting periods for preexisting conditions, not permit companies to jack up premiums once they find out there is someone in that group who is sick.

I think the net effect of that is to raise premiums. It might not decrease to 30 million uninsured, it might go to 36 million uninsured. I am not sure that will address the fundamental problem of people without health insurance coverage in this country.

Mr. ALTMAN. One possibility, if you were to go this incremental is to create a catastrophic Federal pool of dollars, so what you would basically say to insurance companies, do that, if you wind up with a very sick person, the add-on dollars will come out of this pool, therefore limit what that experience or community rate would cover and thereby drive the premium down. This is a proposed part of an earlier effort back in the midseventies.

Mr. WAXMAN. Senator Long's?

Mr. ALTMAN. No, actually it was Congressman Mills that proposed it. It was a different version than Senator Long's.

Mr. WAXMAN. Would we call this legislation the catastrophic protection?

Mr. ALTMAN. No, no. I think we will figure out some way. What I was trying to address is what you were aiming at. If you find out where it is those big expensive cases are that just jack up the community rate, and you require essentially a sharing among a group that includes only the sick, that is not a good plan.

There ought to be ways of extracting those high cost cases and having them paid on a broader basis.

Mr. WAXMAN. You have been very generous with your time and sharing your expertise. We thank you so much. We look forward to talking to you further.

We are being summoned to the House floor for a series of votes. We are going to have to recess and come back to this room at 2:30—well, let's make it at 2 o'clock. We will come back here at 2 o'clock.

[Whereupon, at 12:10 p.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.]

AFTER RECESS

Mr. WAXMAN. Our last panel includes representatives of the two largest segments of the provider community: Hospitals and physicians. Certainly, much of our attention in this hearing has been on finding effective and appropriate policies for controlling the growth in expenditures for these services. I also recognize that we need the expertise and the constructive participation of the provider community as we undertake fundamental health care reform. As all of our witnesses today have stated, this is a difficult and complicated task. While there is little debate about the necessity of cost containment, there remain significant differences about how to achieve this goal.

It is my hope that the hospital and physician communities will be as diligent and specific in their recommendations for controlling health care costs as they have been in their analyses of the causes of cost increases. Our first witness is Richard J. Pollack, executive vice president of Federal Relations of the American Hospital Association. Mr. Pollack has held a number of senior positions with the association over the last 10 years. Our final witness is Dr. Raymond Scalettar, a member of the board of trustees of the American Medical Association, and a practicing internist in Washington, D.C.

Gentlemen, let me welcome you to our subcommittee and thank you for being here today. I would ask each of you to keep your oral summary to 5 minutes, as we will include your full written statement in the record. Mr. Pollack, will you begin?

STATEMENTS OF RICHARD J. POLLACK, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; AND RAYMOND SCALETTAR, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Mr. POLLACK. Thank you, Mr. Chairman. I appreciate this invitation to testify and participate in this hearing, and would like to commend you for your outstanding leadership and commitment in addressing this very important problem and difficult issue.

There is no question about the need for health care reform.

As caregivers, hospitals see the human consequences every day in our emergency rooms, where we attend to the care of children, or adults with preventable, treatable conditions.

We see it in our delivery rooms where tiny babies are born who had no prenatal care, and we see it in our operating rooms, where people have had too little care, and seek it too late.

As administrators we see the inefficiencies that result from a lack of incentives that prevent providers from working in collaboration where: One provider is paid on a per admission basis and another is paid on fee-for-service basis.

Many cannot combine their efforts because of the chill of being challenged on antitrust grounds.

As administrators we also see the inefficiencies that result from the focus on managing costs instead of managing care or the health status of individuals. We see the frustrations of administrative costs, which are consuming an everincreasing quantity of health care dollars, and we see it from a lack of accountability from all stake holders where everyone is one step removed from the economic consequences of their actions.

Clearly, the current system is a jumble of different programs with conflicting and often perverse incentives that has evolved by default, not by vision or decision.

As hospitals we want to see a nation where every single American is given a dignified access point to the health care system, where no citizen is at the risk of becoming financially bankrupt as a result of illness or injury.

We want to see a system in which there is value in the provision of health care services. We have developed a proposal we believe accomplishes these objectives, and it is detailed in our written statement.

It is a pluralistic model that builds on the strengths of the current system. It takes the approach of combining employer-mandated plans with a new public program to cover those with no connection to the workforce. And it is generally similar to the approach taken by the Pepper Commission, as well as your bill, Mr. Chairman. It is a starting point. We are not locked in.

We are currently evaluating that. As you might expect the major area where we differ centers around cost control, or providing value.

At the same time we recognize the price of universal coverage is a meaningful cost control. For us the issue of cost control comes down to two basic and fundamental questions.

The first, how do we contain costs rather than shift them from one payer to another, or from avoiding risk to managing risk on the insurance side.

The second key is how do we assure hard choices about cost containment are made fairly, and in the public eye, rather than through de facto rationing by providers.

Addressing rising health care costs means more than controlling or ratcheting provider payments. And unless we begin to deal with the root causes of health care inflation and honestly confront those costs, we will never bring it under control. That means looking at reducing unnecessary care. It means looking at why hospital expenses go up—the bulk of which are out of our control—and relate

to labor costs, drugs and equipment, and also address some unrealistic societal and patient expectations.

Also, I would say you can't get costs under control unless you also deal with some deepseated social problems like malnutrition, AIDS, substance abuse and crime.

In terms of concrete proposals, Mr. Chairman, we support efforts to reform the small group health insurance market. We support incentives for management of care. We support reduction of unnecessary care through practice guidelines. We support providing more information to consumers. We support the elimination of costly State mandates. We favor malpractice reforms. We favor guidelines for the use of high technology and specialized services. We would like to see reform of antitrust laws that impede collaborative cost containment initiatives. We would like to see efforts to minimize administrative costs through uniform billing and claims processing.

We support the widespread use of living wills and directives, to improve patient self-determination, to limit nonbeneficial final care. And we also support the establishment of a minimum basic benefits package and a process for determining how you arrive at that, and the public expenditure of funds set aside to achieve it.

At the same time, we have real concerns about elements of several proposals that take a rigid regulatory approach and fail to address the underlying causes of health care inflation.

For example, given our Medicare and Medicaid experience we are skeptical about the utility of applying those rates to all payers.

Quite frankly, that linkage and the linkage it has to the Federal budget process, which is driven by deficit reduction imperative, rather than the development of sound health policy, is something we find to be very problematic.

Moreover, and most significantly, and I will conclude here, those approaches do not address the most rapid growth in our Nation's health care system which is the movement of expensive medical technologies out of the hospital setting to freestanding centers which don't have the same accountability as hospitals do when it comes to monitoring quality and utilization.

Finally those approaches perpetuate the current problems of our system by locking into place the fragmentation of care instead of changing the underlying incentives in providing health care services.

We think we need a system instead of a process of micro managing medical transactions. The bottom line is real cost containment must realign these incentives and change the way we deliver health care services and change the way they are delivered and consumed.

Mr. Chairman, I appreciate the opportunity to be before you and I would be happy to answer questions in terms of more details in regard to our specific proposal and where we are insofar as the cost control aspects are concerned.

[Testimony resumes on p. 355.]

[The prepared statement of Mr. Pollack follows:]

*Statement
of the
American Hospital Association*

Mr. Chairman, my name is Richard J. Pollack, Executive Vice President of the American Hospital Association. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to have this opportunity to testify on the cost containment strategies used in some of the legislative proposals on national health reform and share with you elements of AHA's reform proposal. Developing consensus is a difficult task, but we are pleased to see that so many individuals and groups have stepped up to the challenge of developing consensus around a plan for health care reform. The choices to be made are difficult ones and we commend your leadership in this critical debate. While there are many differences in the approaches to health care reform being discussed, all of the proposals share one thing: a desire to remedy the serious health care cost and access problems we face.

The Need for National Health Care Reform

As providers of care for the insured and uninsured alike, and as advocates for the health care needs of the poor, hospitals are distressed to see growing numbers of uninsured and underinsured, deterioration in private insurance coverage, and growing gaps in public programs, because this means people will seek too little care, and will seek it too late. We see the human consequences in our emergency rooms, where we deliver the tiny babies of women who received no prenatal care, and where we attend to the acute illnesses of children or adults with preventable, treatable conditions.

It is increasingly obvious that the cracks in the health care system are much wider and deeper than we thought, that all segments of the population are now affected, and that we won't be able to solve the crisis of needed access to health care services unless we simultaneously, and successfully, grapple with

the equally profound cost crisis. The evidence is certainly grim on the access side, and touches all of us in one way or the other:

- Thirty-three million people lack health insurance entirely, and almost twice that many are intermittently uninsured. During a recent 28-month period, 63 million people lacked coverage at some point.
- Many more fear that their insured status is precarious, something they could lose as a result of any number of events they cannot control -- the death of a spouse, loss of a job, changes in an employer's insurance plan, or the simple deterioration of their own health.
- Many of those who do not have insurance still cannot pay for needed services, because they have pre-existing conditions excluded under their policy, or because the services they need (long-term care, psychiatric care, or rehabilitative care, for example) are not covered for anyone under their plan, or (in the case of public program enrollees) because reimbursements are so low that their insurance card has little purchasing power in the health care market place.

The news is also grim on the cost front.

- Health care costs are growing rapidly, at a time when our GNP is not. Between 1983 and 1989, non-hospital health care expenditures grew from 6.2 percent of GNP to 7.1 percent of GNP. While expenditures for hospital inpatient and outpatient care remained relatively steady (at 4.3 percent of GNP in 1983 and 4.5 percent of GNP in 1989), expenses

for all health care combined rose from 10.5 percent to 11.6 percent of GNP during this period.

- Group health insurance premiums have been increasing at an average of 16 to 18 percent a year for the past several years, and increases for many small businesses are much higher still.
- The costs of unsponsored care (care for which no payment or government subsidy was received) are rising, and reached \$9 billion in 1989 for hospitals. Hospital underpayments from Medicaid are rising even more quickly, and reached about \$4.3 billion in 1989.

What makes the twin problems of access and cost so intractable is the fact that they feed on each other. Unsponsored care and government payment shortfalls lead to cost-shifting. Cost-shifting fuels already-increasing health care costs, which translate to higher premium costs, followed by coverage cutbacks, which lead to more unsponsored care. Noncoverage and inadequate coverage lead to delayed care, which is also more costly.

AHA's Proposal

Hospitals and physicians can and should exert leadership in these issues, working at the local level with their communities to attack these problems and working at the national level with Congress to achieve overall reform of the health care system. Hundreds of hospitals across this nation have spent more than a year clarifying and discussing the pressing problems with our health care system and deliberating alternative plans of action. We began with the

premise that all of us -- citizens, providers, insurers, purchasers, and government -- will need to be a part of the solution, and therefore will have to make changes that may be difficult to achieve. Our resulting proposal is called *A Starting Point for Debate*--because we intend it not as a blueprint but as a lightening rod for comment, criticism, suggestions, new ideas and approaches.

A copy of our proposal is attached to our statement. In summary, the strategy we propose has five parts:

- *Universal coverage* would be provided through a combination of employment-based coverage of basic benefits and a new single public program consolidating and expanding Medicare and Medicaid. Catastrophic coverage would be provided under the public program for everyone, whether covered under the public or a private program. Tax and other laws would be revised to help employers sponsor coverage and ensure the availability of more affordable private insurance offerings.
- *A single set of basic benefits* would be defined for the public plan and would serve as a benefit floor for private health insurance plans. To ensure access to appropriate and effective care, a full range of services from preventive through long-term care would be included and would be linked to overall cost containment goals through budget targets for basic benefits set biannually by Congress, assisted by a new national public/private commission.
- *Value* would be ensured through health care delivery, financing, and other reforms designed to assure that care is managed and coordinated,

that only appropriate and effective care is provided, and that system-wide costs are contained.

- *A sustained commitment to biomedical and health services research* would help to ensure that all Americans continue to benefit from medical and delivery system advances.
- *A coherent and comprehensive approach to meeting health manpower needs* also must be adopted in the United States if we are to realize the goal of adequate access to health care services to everyone.

Our plan has grown out of a vision to improve the current health care system and to refocus and redirect its goals. One focus of debate concerning the present system is cost. Employers, private payers, and public payers are each trying to control their own costs, most commonly by avoiding rather than managing risks, shifting costs to others, or simply limiting payments to providers. But these mechanisms do not address the root causes of rising costs, and they do not help to manage total costs within the health care system. In terms of cost containment, the dilemma is how to assure that costs are managed rather than shifted from one payer to another, and how to assure that the hard choices about containing costs are made fairly and in the public eye rather than taking the form of de facto rationing by providers in response to payment policies. We believe that this dilemma can only be solved, and long-term reform achieved by, a strategy that is systematic and comprehensive.

While cost will remain a predominant concern in the debate over the future of our health care system, we strongly believe that we also must guarantee

necessary access to basic health benefits and, at the same time, fine-tune the effectiveness of the health care we deliver so that access and quality as well as affordability are hallmarks. The overall dilemma of health care reform is how to strike a balance between cost, quality, and access to health care services.

Economic Discipline Within AHA's Proposal

In response to comments and suggestions we have received on the *Starting Point*, the AHA is reexamining the cost containment approaches and provider payment mechanisms contained in our strategy. During this reexamination, we will be testing and going beyond the points of consensus reached by our hospital members last year. It is becoming increasingly clear that current provider payment mechanisms present serious shortcomings from everyone's perspective, and we must take a hard look at how to achieve a more rational approach. But a more rational approach is not a matter of simplistically capping the amount of money we spend on health care services. True health care reform must realign the incentives of health care providers, payers, and patients and change the way in which health care services are delivered and consumed. That is why we have favored an incentives-based approach to cost containment -- an approach in which individual physicians, hospitals, and other providers are held accountable for their performance. By changing providers' incentives to deliver health care services efficiently and effectively, we can begin to focus on changing the underlying causes of health care cost increases. Performance accountability would be built into the system through the use of medical practice parameters, wide availability of information on individual practitioner and provider cost and quality outcomes,

and guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services.

Incentives among providers also should be compatible so that all providers work toward common objectives. This would mean eliminating the currently conflicting incentives of paying hospitals on a per-admission basis while paying physicians and other practitioners on a fee-for-service basis, which can encourage hospitals and physicians to work at cross-purposes. Per-admission payments encourage hospitals to economize while fee-for-service payments encourage physicians to do more.

Similarly, incentives between providers and purchasers should be realigned to make objectives compatible. Risk-sharing arrangements that focus both purchasers and providers on maintaining and improving the health status of covered populations should be encouraged. For example, purchasers and providers in a region might share each year any overall financial gains or losses incurred in serving a defined population enrolled under a particular arrangement for management of care. Managed care should be promoted with a broader, longer term focus on providing coordinated care over time and across providers in order to improve the health status of enrolled individuals and control costs while ensuring quality.

In addition, the overall climate for cost containment and the opportunity for advancing new initiatives would be improved by reform of the medical liability tort system to obviate the need for defensive medicine; by widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care; and by changes to

antitrust law and other legislative and regulatory barriers to effective cost containment.

By changing the incentives of providers, payers, and patients we can achieve more than cost containment -- we can foster a new sense of economic discipline among all of the participants in our health care system which could make for lasting reform. But if we are to achieve real and meaningful reform of the health care system, we need to form a partnership among providers, insurers, consumers and government aimed at addressing the underlying causes, not just the symptoms of the problem. The AHA will be working with a broad cross section of interested parties in an effort to better understand what propels our health care system and to develop recommendations for change. When our work is complete, we would be happy to share with this committee any further suggestions for maintaining economic discipline within the health care system.

Cost Containment Strategies in the Major Reform Proposals

We applaud the efforts of those members of Congress who have crafted legislative proposals for health care reform, assuring that this issue will receive the serious attention it deserves. Despite differences in approach, some of these proposals are quite similar in philosophy to the AHA's national health reform strategy and many others have bases from which to build consensus for national health care reform. In terms of cost containment initiatives, however, we find that many of these reform proposals fall short of what we believe to be the appropriate goal: addressing the underlying causes of cost increases.

One striking feature is that despite the large number and variety of reform proposals currently being considered, the cost containment aspects of these proposals are quite similar. Several of the major proposals employ a highly structured, top-down regulatory approach to cost containment; that is, they call for setting a single national health care expenditure target and then allocating that fixed pot of dollars in various ways among various types of health care providers. For example:

- S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act" sponsored by Senators Mitchell, Kennedy, Riegle, and Rockefeller, would establish a Federal Health Expenditure Board, an independent entity that would set national expenditure goals in total, for specific segments of the health care industry, and for states and regions. The Board would then negotiate with representatives of providers and purchasers to establish rates "and other methods" (presumably capacity and volume restraints) to achieve these goals. Determination of the overall health care spending target would be left to the discretion of the Board.

- H.R. 3205, "Health Insurance Coverage and Cost Containment Act of 1991" introduced by Congressman Rostenkowski, takes a formula approach to cost containment. The national health expenditure target would be determined based on current spending for a defined set of health care services, basically those services that are currently provided under the Medicare program plus unlimited inpatient hospital services for children and certain pregnancy-related services. This dollar level of spending would be increased each year by the percentage increase in GNP

plus an additional 4 percentage points in 1993 and 1994. Over time, this add-on would be reduced and after the year 2000, the percentage increase in health care expenditures would be limited to just the increase in GNP. Adjustments would be made only for changes in the size of the U.S. population. The bill would establish a Health Care Cost Containment Commission that would be responsible for conducting negotiations with professional and other associations to distribute the available dollars among the different classes of providers. The Secretary of Health and Human Services would be responsible for setting payment rates that are consistent with these expenditure totals. As specified in the bill, payment rates must be based on Medicare payment methodologies -- DRG-based payments for hospitals and RBRVS-based payments for physicians.

- H.R. 1300, "Universal Health Care Act of 1991" sponsored by Congressman Russo and others uses a Canadian-styled approach to health care cost containment. The Secretary of Health and Human services would set a national health budget and a health budget for each state. The total level of health expenditures would be set so as not to exceed the level of spending for covered services in 1992. This amount would be increased each year by the annual percentage change in GNP. Hospitals would be paid using "global budgeting." That is, an operating budget (excluding capital expenses) would be established each year by the Secretary for each hospital. The budget allocation would provide a ceiling within which each hospital would have to operate. Physicians would be paid on a fee-for-service basis using a national RBRVS.

First, we believe the approach embodied in these proposals would merely perpetuate many of the current problems with our health care system. Setting expenditure targets for each sector of the health care field will lock into place the fragmentation of care, rather than moving toward more coordinated and better managed care. Past experience also suggests that there would be a great temptation to set spending goals and payment rates at current levels. But there is a danger in doing so. Freezing into place current expenditure patterns and levels simply freezes into place all of the problems and conflicting incentives in our current system of health care delivery. This approach does not address the real problems that initiated the call for reform in the first place.

Second, it is unrealistic to effectively cap spending at current levels while simultaneously expanding access to millions of people. Any cost containment mechanism needs to be flexible enough to accommodate increased spending due to changes in the size or demographics (e.g. age) of the population served, changes in the needs of the population served, and appropriate changes in utilization that result from the continuing evolution of health care technology and delivery.

Finally, controlling health care *spending* by payers will not necessarily control health care *costs* experienced by providers. Limiting the total dollars that are made available for health care services without somehow changing the underlying incentives for providing and using health care services is just another example of a budget-driven quick fix which, as we know through our experience with such fixes in the Medicare program, have not produced the needed solutions to our health care problems. Simply

constraining spending may have the effect of manipulating provider behavior, but it may be in ways that are neither optimal nor desirable in terms of assuring that patients have access to quality health care services.

Furthermore, we must change the environment within which providers function, so that it is more conducive to cost-effective behavior. Chief among the needs here are tort and antitrust reforms.

H.R. 2535, the "Pepper Commission Health Care Access and Reform Act of 1991" introduced by you Mr. Waxman, Chairman of this Subcommittee, takes a somewhat different approach to cost containment. No explicit expenditure targets are set under this proposal. Rather, the proposal seeks to control costs in the system by controlling provider payment rates. Under this bill, provider payment rates would be set predominantly by the federal government, since the public plan created by the proposal would pay providers using Medicare rates and any qualified employer health plan also would be allowed to elect to pay providers at the Medicare rate. Similarly, a second bill recently introduced by Congressman Rostenkowski, H.R. 3626, the Health Insurance Reform and Cost Control Act of 1991, would allow any purchaser of care to elect to pay providers of care Medicare rates (adjusted to reflect differences in the benefits and populations served). Providers would be required to accept the rates as payment in full, subject to a civil monetary penalty. (As mentioned above, Congressman Rostenkowski's other bill, H.R. 3205, also sets rates within the health care system based on Medicare payment methodologies.) Effectively under these proposals, Medicare payment rates would be used by the public plan and would serve as ceilings for payment rates used by private insurers.

The Pepper Commission argued that Medicare's payment rules reward providers for delivering services efficiently. But fixing provider payment rates at Medicare levels will simply lock in inadequate payment rates, which when applied to all services delivered, will likely have serious consequences for access to and the quality of care. Overall, hospitals have been losing money treating Medicare patients for the last three years. The AHA projects that in FY 1992, aggregate Medicare payments to hospitals will be 10 to 15 percent less than the costs incurred treating Medicare patients. Because of increasingly inadequate Medicare payment rates, hospitals have had to shift unfunded costs onto the shoulders of other payers. Institutionalizing inadequate payment rates throughout the health care system will only exacerbate the problem. This approach may put an end to the financial shell game known as cost-shifting, it does not provide a structure for making the difficult choices that would have to be made or for reconciling consumers' expectations with available funding.

H.R.3410, "The Health Access and Affordability Act of 1991" introduced by Representative Kennelly takes yet a different approach. On the access side, H.R.3410 stops short of universal access, but would expand access significantly by broadening Medicaid -- chiefly by eliminating the categorical eligibility tie and covering everyone whose income is below 133 percent of the federal income poverty guideline -- and by instituting small group insurance market reforms and tax incentives for the self-employed to purchase insurance. On the cost-control side, the bill would rely predominantly on promoting managed care -- defined loosely as programs in which insurers monitor the utilization of services by doctors and hospitals -- not only in the private sector but under the Medicare and Medicaid programs as well. Managed care would be

promoted by waiving all freedom of choice provisions under Medicare and Medicaid and by prohibiting the application of state laws governing the conduct of such plans on matters such as selection of participating providers, alternative payment rates for participating providers, utilization review practices, and mandated benefits. The removal of these restrictions to managed care are not balanced by the addition of any federal conditions or protections for consumers in general or for Medicare and Medicaid beneficiaries in particular.

While we support the effective management of care, we are concerned that to many, "managed care" has come to simply mean a system of selective provider contracting and/or external utilization review. This is managed cost, not managed care. Many so-called managed care programs in operation today do nothing to assess or manage the health status of patients. They often do nothing more than enforce external utilization review, which can impose the discipline of cost consciousness but can also increase administrative costs, inappropriately interfere with physician-patient relationships, and cause distress over improperly denied health insurance claims.

True managed care requires a broader, longer-term focus on improving the health status of enrolled individuals and controlling medical care costs while ensuring quality. Managed care means assessing patient needs, then planning and organizing care so that all needed services are efficiently provided and care is coordinated over time and across providers. Moreover, because managed care should seek to improve the general health status of its enrollees, it should be concerned with all aspects of care, including promotion of cost-effective preventive services and the long-term management of chronic

illness. On the issue of promoting managed care under Medicare and, particularly, under Medicaid, we believe H.R.3410 would prematurely wipe away all beneficiary protections in an effort to achieve cost savings. It is our understanding that the Health Care Financing Administration is already working on how to promote managed care under these programs, including what protections are needed to ensure that the pursuit of cost savings does not subject beneficiaries to substandard care or to inappropriate limitations on their access to needed services. Such protections are necessary when the ability of individuals to "vote with their feet" is removed. Furthermore, if the desire is to promote managed care under the Medicaid program, the single most effective action would probably be a guarantee that any Medicaid beneficiary entering a managed care plan would be covered for an entire year. Currently, because many Medicaid eligibles move in and out of eligibility on a monthly basis, administrative costs are exceptionally high, and it is extremely difficult to get health care conditions under control. AHA would be happy to work with the authors of these bills to refine the current approach to defining and promoting managed care.

Overall, we believe the main failing of these approaches to cost containment is that they do not address the issue of purchaser, provider, and patient incentives and do not encourage the efficient delivery and use of health care services -- they simply limit health care spending and provider payment rates, assuming that providers can absorb resulting losses and "adjust" the way in which they deliver care enough to be able to continue to provide high quality care to a greater number of people. The hard choices this nation faces demand more from us all. Providers should not be expected -- and are increasingly unwilling -- to be left alone to figure out how to "cope" with fewer dollars.

We stand willing to do our part, but it is time for us all to pull together in this task.

Conclusion

Meaningful health care reform is not as simple as reducing spending. Limiting spending, primarily through squeezing payments to hospitals, physicians, and other health care providers will likely have serious consequences for the delivery of health care. Rather, health care reform must seek to strike a balance between cost, quality, and access. Reform efforts should encourage efficiency within our health care system and reduce costs where possible, but at the same time improve access to health care services and maintain the quality of the care we receive. Above all, health care reform should establish shared responsibilities among government, business, labor, insurance companies, providers, and consumers.

NATIONAL HEALTH CARE STRATEGY:

A starting point for debate

Toward a healthy america

The healthiest nation in the world -- that is the American Hospital Association's vision for this country. To help achieve that goal, our focus is on affordable access to needed health care, including preventive services. This nation must come together on strategies to promote health and well-being and to assure judicious use of a health care system reshaped to put patients first. This will require strong leadership in forging partnerships with organized medicine, other health professional groups, business, government, labor, insurers, the educational system and, above all, the American public. The AHA asks simply, but importantly, that the give-and-take begin.

Health care in the United States is at a crossroads. Our system routinely delivers the best health care in the world but is beset by major problems: the ranks of the uninsured and underserved are large and growing; health care costs continue to escalate; and many providers of vital services are caught in a financial squeeze between resources and responsibilities.

The public shows increasing signs of concern about the state of their health care system. Even the overwhelming majority of Americans who enjoy easy access to needed care sense that something is wrong. They know that health care and health insurance are very expensive; that getting health services may depend on where you work, where you live, and how much money you have. Part of the problem is that the current health care system is a jumble of individual programs that have evolved by default, not by vision and design.

Significant reform is needed. We must clearly establish two central objectives for our health care system and its reform: improvement in the health status of all Americans by maintaining health and minimizing the effects of illness, and greater economic discipline in the use of health care resources.

Our starting point has to be the guarantee of necessary access to preventive health services and other basic health benefits for the 33 million Americans who currently have no health insurance and the millions more who are inadequately covered. At the same time, we must make changes to improve the efficiency and effectiveness of our system so that affordability as well as quality are hallmarks.

All of us--citizens, providers, insurers, purchasers, and government--will need to make changes.

- ❑ Individuals must accept greater responsibility for adopting a healthy lifestyle -- the effects of smoking, substance abuse, obesity, poor nutrition, and inadequate exercise on individuals' health and on the cost of health care are too great. They must also use health care services efficiently and appropriately.
- ❑ Providers must develop a heightened awareness of economic concerns and weed out unnecessary services, spurn the unnecessary duplication of costly technology, and eliminate excess capacity by converting it to other uses or shutting it down. Hospitals and physicians must forge effective partnerships to help bring this about -- neither can do it alone.
- ❑ Financing and payment systems must be overhauled so that incentives support disease prevention and care in the least costly setting as well as efficient performance overall. Such systems must also be fair and provide adequate payment, lest the vitality of our health care system be compromised.
- ❑ Employers and other purchasers need to structure benefits and cost sharing under their programs so that they promote disciplined behavior on the part of insured beneficiaries.
- ❑ Insurers need to focus on risk management, rather than risk avoidance, and on keeping program administration costs to the absolute minimum. Mechanisms aimed at enabling universal coverage at an affordable price should be adopted as the central goal of the insurance industry.
- ❑ Government must live up to its promises.

As a society, we must address several hurdles to cost-effective care: the lack of consensus on the appropriate limits of treatment; unrealistic patient expectations; a medical liability climate that encourages defensive medicine; and deep-seated social problems like poverty, substance abuse, malnutrition, inadequate housing, and crime, all of which impair health status and drive up health care demand and costs. While the health care system alone cannot ensure improved health status, hospitals, physicians, other caregivers and major stakeholders can and should exert leadership in their communities, working with other social agencies and groups to attack these problems.

Hundreds of hospitals across this nation have spent more than a year clarifying and discussing the pressing problems with our health care system and alternative action plans. Based on this effort, the American Hospital Association now offers this *Starting Point* designed to sharpen and stimulate the debate on national health care reform.

Our hope is that in the months ahead this *Starting Point* will serve as a lightning rod for comment, criticism, suggestions, new ideas and approaches. Above all, we see it as a worthwhile basis for dialogue with everyone who has a stake in our health care system.

Important work lies ahead -- work that will test the collective leadership and vision of all. The American Hospital Association and the hospitals it represents ask you to join with us in meeting this challenge.

Goals for reform

As a beginning point, the Association offers nine goals that any reform plan must meet:

- ❑ **Basic health services available to all:** All individuals must have access to, at a minimum, a package of basic health care services.
- ❑ **High quality:** Delivery and financing arrangements must (1) ensure the effective management of medical conditions, including the coordination of care among providers and over time; and (2) promote continuous improvement in the quality of care.
- ❑ **Affordable:** Patients and their purchasers must be able to select benefits and delivery arrangements that emphasize value, so that needed care, delivered in the least costly, medically appropriate manner, is obtainable for what they are willing and able to pay.
- ❑ **Community focused/patient centered:** Delivery and financing arrangements must be managed at the local level to recognize appropriate community variations in medical practice consistent with national standards, health care needs, and the resources available in the community.
- ❑ **Sufficient supply for timely access:** Delivery and financing arrangements must encourage enrollees or beneficiaries to obtain care when and where it is most likely to change the course of a disease or prevent avoidable illness, loss or impairment of function, or death.

- ❑ **Efficiently delivered:** Delivery, financing, and insurance systems must align the incentives of facilities, caregivers, payers, and users, to eliminate conflicting interests, discourage unnecessary duplication of services, and promote continuous improvement in the efficient use of resources to restore or preserve health.
- ❑ **Adequately and fairly financed:** To eliminate cost-shifting, any public or private financing program must itself bear the full cost of the services provided to its enrollees or beneficiaries under the benefits it promises.
- ❑ **User-friendly:** Delivery and financing arrangements must enable patients, practitioners, providers, purchasers, and insurers to obtain, deliver, and pay for care with minimum uncertainty, confusion, and paperwork.
- ❑ **Conducive to innovation:** Delivery and financing systems must promote development and dissemination of new and more effective methods of treating and preventing illness and delivering services.

All of the goals may not be equally satisfied at any given point in time. Some may require staged implementation and some may need to be tempered to promote the achievement of others.

AHA's strategy for reform

This health care system reform strategy builds on the strengths of our existing pluralistic health care delivery and financing systems to enhance access by everyone to affordable, quality health care. Health care in a country as culturally diverse as ours is very much a local affair; what makes sense in some communities may be infeasible or ill-advised in others. Pluralistic financing facilitates local control over health care delivery, permitting variations based on area resources and priorities. Moreover, while the administrative costs of a pluralistic system of financing might be higher than a monolithic system such as Canada's, a pluralistic approach both spurs innovation and enables health care costs to be spread among individuals, business, and government rather than be concentrated as a burden on one funding source. But, to maintain a pluralistic approach, significant efforts are needed to overcome its serious flaws.

The pluralistic strategy we propose as the starting point for debate has four parts:

- ❑ **Universal coverage** would be provided through a combination of employment-based plans and a new single public program consolidating and expanding Medicare and Medicaid. Tax and other laws would be revised to help employers sponsor coverage and ensure the availability of more affordable private insurance offerings. Catastrophic coverage would be provided under the public program for everyone, whether covered by the public or a private basic health benefits program, when required premiums and cost-sharing reach extraordinary levels compared to an individual's ability to pay.
- ❑ **A single set of basic benefits** would be defined for the public plan and would serve as a benefit floor for private health insurance plans. To ensure access to appropriate and effective care, a full range of services from preventive through long term care would be included and would be linked to overall cost containment goals through budget targets for basic benefits set biannually by Congress. A public-private commission would match the benefit package to the dollars available through the federal budget and beneficiary cost sharing by those able to contribute.
- ❑ **Value** would be ensured through reforms in health care delivery, financing, and other approaches aimed at managing and coordinating care, at providing only appropriate and effective care, and at containing both provider costs and consumer demand.
- ❑ **The nation's commitment to biomedical and health services research and to ensuring an adequate supply of physicians and other health care professionals** would be sustained and appropriately focused.

A staged and orderly transition is proposed to minimize disruption as the nation moves from the current system to the new program.

Universal coverage through employment-based plans and a new public program

The AHA proposes that all individuals be covered for basic health care services, either through employer-sponsored programs or a consolidated public program combining and expanding Medicare and Medicaid. The public program would also provide catastrophic coverage for all.

Employment-based coverage

The AHA proposes that employment-based coverage of basic benefits be encouraged in stages through a number of mechanisms. The first stage would grant the same tax advantages to self-employed individuals and owners of unincorporated businesses for the purchase of health benefits (100 percent, rather than 25 percent, deductibility of premiums as a business expense) that large employers and their employees enjoy.

Self-insured businesses would assume responsibilities and obligations for health care coverage that are equal to those of insured businesses, such as participating in state risk pools. Targeted tax incentives and hardship funds would be made available to employers to help finance benefits; for example, special tax credits for small businesses or for businesses in the first five years of operation.

Employers would be expected to pay at least 50 percent of health care coverage costs for full-time permanent employees and their dependents and a prorated amount for part-time permanent workers and their families. The coverage provided would have to meet the minimum specifications of the federally-defined basic benefit package, although employers would be free to offer more than basic health benefits if they and their employees so desire. Employees would be given strong incentives to accept employer-sponsored coverage, including tax incentives (e.g., tax credits) for low income employees to help cover their share of premiums.

To maximize the use of health care dollars for the actual delivery of care, private insurers must work with providers and practitioners to reduce the high cost of unnecessary paperwork and inefficient claims review and processing mechanisms.

The AHA also proposes that private health insurance be reformed to preclude the use of underwriting practices, such as preexisting conditions clauses, that are designed to avoid rather than manage risk, and to develop reinsurance mechanisms and insurance pools at the state level to spread risk so that more affordable insurance is available to small businesses and individuals, such as the self-employed and medically uninsurable. State laws requiring employers or employees to pay for coverage exceeding the federally-defined basic benefit package would be preempted, providing private insurers with the opportunity to design a broader array of insurance packages at different affordability levels.

As a backstop source of coverage, small employers (with fewer than 25 employees) and the self-employed would have the option of purchasing community-rated basic benefits protection from the public program (discussed below), as would any individual unable to obtain private health insurance within their financial means. For individuals not able to

join a group for insurance purposes (such as the self-employed), the community-rated basic benefit premium under the public program would likely be lower than the premium for comparable private *individual* coverage.

There would continue to be an incentive for small employers and private insurers to develop innovative private group insurance arrangements, however. Coverage under the public program would likely be more expensive than premiums for comparable private *group* coverage, even though it would be community rated, because the public program primarily would cover individuals with higher than average expected costs, e.g., the poor, the elderly, and the disabled. This safety net of access to coverage should not pose any unfair competitive threat to private insurers so long as provider payment rates in the public program are adequate and eliminate cost shifting. Private insurers, government, and providers have a responsibility to ensure that this is the case.

At the end of a specified transition period, possibly three years, any individual unable or unwilling to obtain basic benefits coverage through the private health insurance market would be automatically enrolled in the public program when they seek services, if they do not enroll on their own. If employed, their employer would be responsible for paying at least half of the community-rated premium for that coverage. Individuals enrolled in the public program would be expected to pay premiums based on a sliding scale related to income.

A new public program

AHA proposes that a new federal public program be established to provide basic benefits coverage to everyone not covered by employer-based or other private plans, and to provide catastrophic coverage to everyone in the country.

The public basic benefits program would consolidate and expand Medicare and Medicaid, covering a broader scope of services than government programs now provide, in particular long-term care and outpatient prescription drugs. The same broad scope of basic benefits would be required as a minimum for private health insurance coverage. The public basic benefits program could be expected to cover not only the elderly, disabled, and all the poor, but the unemployed, temporarily employed, self-employed, and employees of small firms unable or unwilling to obtain private coverage.

The AHA proposes that government's first priority in funding this public plan be targeted at those least able to afford benefits. Enrollees in the public program with income less than 150 percent of the federal poverty level would receive fully subsidized basic benefits,

with the possible exception of minimal copayments and deductibles. Those with income greater than 150 percent of the federal poverty level would make contributions to premiums and copayments and deductibles scaled to their ability to pay.

Under these specifications, the public program would pay for all Medicaid recipients in full and would pay all or part of the premiums and cost-sharing for most current Medicare beneficiaries. Approximately 8.1 million elderly (27 percent of the elderly) and 46 million non-elderly (21 percent of the non-elderly) would qualify for fully subsidized coverage and many millions more would qualify for partially subsidized coverage.

The public program would also provide catastrophic coverage for all individuals, whether in private or public basic benefit plans, when required premiums and cost sharing reach extraordinary levels compared to an individual's income and ability to pay.

The public program would be financed by a combination of broadly-based federal tax revenues dedicated to an off-budget trust fund and premium contributions by those covered who can afford them. States would gradually be phased out of financial responsibilities under today's Medicaid program, although there could be an offsetting federal-state realignment of financial responsibility for other domestic programs.

The public program would be administered through regional contracts with private insurers who demonstrate the ability to hold down the administrative costs of the program and the sophistication to work with the federal government and providers at the regional level on the development of innovative contractual and payment mechanisms for effective management of care.

Basic benefits defined and linked to affordability targets

The AHA proposes an approach to defining coverage that would apply both to the new public program and to employment-based and other private plans. It is designed to ensure access to needed services, encourage health promotion and disease prevention, discourage inappropriate and unnecessary utilization, and reconcile universal access with judgments of affordability.

- ❑ **Basic benefits** would cover the full range of care -- from preventive through long-term -- to prevent illness, minimize disability, restore function and health, and alleviate suffering. Covered services would include effective preventive care, such as immunizations, prenatal and well-baby care, and mammography; outpatient care in physicians' offices and hospital outpatient and emergency departments; and inpatient care, including medical rehabilitation, psychiatric, and substance abuse. Other important coverage would include: skilled nursing, intermediate, and

residential long-term care; prescription drugs; home health care; hospice care; and ambulance services. Rather than impose fixed limits on the types or quantities of services covered, a rigorous standard of medical necessity and reasonableness would be regularly applied to help keep costs down.

- ❑ **Deductibles and copayments** would apply to all services except preventive care (although they would be eliminated or reduced to nominal levels for those with limited financial resources under the public program). These cost-sharing provisions are intended to emphasize health and prevention by providing strong incentives for individuals to adopt healthy life-styles and seek early treatment. The catastrophic coverage provided under the public program would ensure that the combination of premiums and cost-sharing did not exceed an individual's ability to pay. This approach, coupled with the management of care provisions and treatment referral networks described below, would ensure access to services and help channel individuals to appropriate levels of care on a timely basis.
- ❑ **Explicit per capita budget targets for the public basic benefits program** would be established and biannually updated by Congress, to serve as an overall constraint in defining the specific features of the basic benefits package and to focus attention on the need to integrate costs and benefits. Since the basic benefits defined for the public program also serve as the minimum required benefit for private health insurance programs, a broad range of private and public groups will have a vital interest in both the setting of budget targets by Congress and in the work of the national public/private commission.
- ❑ **A national public/private commission** would serve two functions:
 - It would provide Congress the information and advice it needs to set the budget targets for the public program, including: the implications for the scope of benefits and the level of cost-sharing of setting the upcoming budget targets at different levels; the adequacy of current revenues to support the public program; and the adequacy of current provider payments under the public program.
 - Working from the targets then set by Congress, the commission would define basic benefits. Allowable approaches for meeting the budget targets would include phasing in expanded benefits, adjusting cost-sharing arrangements, and identifying cost ineffective treatments to be specifically excluded from basic benefits, but would exclude reductions in provider payment below the reasonable cost of delivering services. The commission would make these

decisions through a public process. Providers would not be held liable for refusing to provide services excluded from basic benefits coverage because they are not cost-effective.

Achieving value through health care system reforms

The AHA proposes that significant changes be made to enhance provider and practitioner accountability for appropriate use of resources and to ensure that all care, whether provided under public or private plans, be managed so that patients receive the care that they need, that only appropriate, high quality care is delivered in the least costly manner and setting, and that care is coordinated across the full range of services and over time.

Provider accountability

AHA's recommended reforms in public and private benefit coverage and in delivery and payment arrangements would help sustain otherwise viable facilities that are needed but currently serve large uninsured populations. These recommendations, however, would not help any health care facility that cannot demonstrate value and fulfill legitimate community needs. In order to effectively compete for and manage risks under incentive-based contracts with private and public purchasers of care, all hospitals would need to continually evaluate their mission and performance from both cost and quality perspectives. In any given community, some hospitals might need to close, to merge, to consolidate specialty services, and/or to join systems or form alliances with other health care providers.

Providers and practitioners would be expected to coordinate the care provided to patients across settings and over time. Licensure and accreditation standards would ensure that, at a minimum, all facilities were linked by comprehensive referral and medical record information exchange agreements to facilitate the process of managing patient care across provider settings and to help consumers navigate the health care system more easily.

Performance accountability by providers and practitioners would be built into the system. Specifically:

- ☐ The use of medical practice parameters developed by clinicians would be required to foster state-of-the-art, effective clinical decision-making and to provide a sound basis for purchasers to judge the appropriateness of care provided.
- ☐ Information on individual practitioner and provider cost and quality outcomes would be made available to all purchasers and consumers.

- ❑ Guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services would be widely disseminated.
- ❑ Incentives which reward effective collaboration between hospitals and physicians in the management of care, assurance of quality, and utilization of resources would be established.

It is expected that as these data and guidelines are developed and proven over time, they will be used by some major purchasers of care to establish selective contracting arrangements for certain or all types of care within a region.

Management of care

To ensure adequate management of care, providers and practitioners would be expected to establish their respective roles and responsibilities for managing care to patients within enrolled groups when contracting with purchasers. Purchasers would have to ensure that their overall arrangements with providers and practitioners guaranteed reasonable access to the full range of basic benefits for enrolled groups in specific geographic locations. Negotiations with providers and practitioners would determine what care would be delivered by a given provider or practitioner; how care would be delivered, at what price, and under what conditions; and how quality would be monitored and assured.

A variety of arrangements for effective care management would be needed to reflect the different needs of specific defined populations and the different delivery capacity of providers in diverse geographic areas, but the ultimate goal would be the implementation of delivery arrangements that focus on improving the health status of specific populations and delivering value when it comes to needed medical care.

AHA is not proposing a single model for management of care. Various strategies are being tried around the country, with increasing sophistication, to improve health and to control medical care costs while ensuring quality. These range from early and periodic screening and pre-admission certification and concurrent utilization review programs carried out by insurers or third-party review entities, to PPO and HMO arrangements for managing and paying for the full scope of services from preventive and primary care to inpatient acute and long-term care. Through pluralistic financing, flexibility exists to use any approach that yields the desired result -- improved health status and effective and efficient patient care management -- for the key here is provider and practitioner commitment to effective management of all patient care, not simply a response to insurer incentives and controls.

Aligning payment incentives

To support these efforts, payment incentives for different types of providers and between providers and purchasers must be realigned, so that all parties work toward common objectives. First, new payment approaches for professional and institutional components of care need to be tested. For example, like hospitals, physicians could be paid under separate but parallel methods (for example, separate but prospectively set prices for the professional component of the same unit of service), while the necessary organizational relationships are developed and tested to support integrated payment for both the institutional and professional components of care in those areas where the concept is workable. Ultimately, integrated payment provides the greatest impetus for forging the institutional-professional partnerships needed to achieve cost-effective care. Even in the long run, however, for some areas such as rural communities, a single integrated payment may prove unworkable.

Second, there is a need to identify and test new payment approaches which make a purchaser's incentives and objectives compatible with those of providers with whom they contract. For example, purchasers and providers in a region might share each year any overall financial gains or losses incurred in serving a defined population enrolled under a particular arrangement for management of care.

Improving the climate for cost containment

In addition, the affordability of needed services would be strongly advanced by:

- ☐ Reform of the medical liability tort system to obviate the need for defensive medicine.
- ☐ The widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care.
- ☐ Changes to antitrust law and other legislative and regulatory barriers to effective cost-containment.

A sustained commitment to biomedical and health services research

Health system reform must include a sustained level of governmental and private support for innovation and the evaluation of new approaches. Biomedical research enhances our capacity to diagnose and treat illness; health services research is essential for more complete information on such critical issues as assessing the efficacy of diagnostic and therapeutic regimens and establishing the relationship between treatments and outcomes.

Our future ability to improve the value of health care services will depend in significant part on rigorous evaluation of today's and tomorrow's delivery and payment system innovations.

A coherent approach to meeting health manpower needs

The United States must adopt a more coherent and comprehensive approach to ensuring the availability of the number and types of physicians and other health care professionals needed to provide adequate access to health care services for everyone. Public policy decisions at the national, state, and local levels and local program decisions should all work toward the central goals of adequate supply, efficient use of health care professionals, and appropriate geographic distribution of needed health manpower. Actions designed to deal with these issues should be based on sound assessments of manpower needs and should focus on both the near term and the future.

The AHA proposes the appointment of a national public/private commission to provide a regular and comprehensive assessment of future health manpower needs to support the development of national and state level strategies. It also should provide advice on national manpower training policies and federal funding priorities for educational program and student support. The direction and organization of graduate medical education should be a collaborative effort by hospitals, medical schools, affiliated programs in alternative settings, appropriate national standard-setting agencies, and the Commission.

Adequate supply

AHA proposes a series of actions designed to deal with today's well recognized crisis due to health manpower shortages. We must act now to stabilize existing training programs, promote new programs where needed, reorient training programs to future needs, and attract qualified students to the health professions. Specifically --

- ❑ Funding priorities for educational programs, faculty and students should be directed to those professions and occupations experiencing shortages, both specialty (e.g., primary care) and geographic, and to those programs that train and field more practitioners than educators and researchers.
- ❑ Financial barriers to entry into health care professions should be reduced, particularly for qualified students with limited means and students from minority groups, to expand the pool of potential health care workers.

- ❑ Alternative competency measures (e.g., national examinations or proficiency tests) should be developed to recognize and credit the knowledge and skills attained outside the formal education system through job experience and on-the-job training.
- ❑ Both public and private purchasers of care should pay for the costs incurred by hospitals and other types of providers in training various types of health care professionals. Provider payment arrangements should help solve, rather than exacerbate, access problems caused by shortages of health manpower in specific locales.
- ❑ Graduate medical education should continue to be financed primarily with patient care revenues. Clinical training is an integral part of graduate medical education; the educational function cannot therefore be separated from the patient care function. Extended periods of research by residents and fellows, however, should be supported by funds designated for research purposes.
- ❑ Educational entities, health care providers, and community leaders should form consortia at the local or regional level to avoid inefficiencies in manpower training by coordinating their health occupations education programs to make the most efficient use of faculty and other resources, facilitating movement of students from one program to another, and promoting innovative approaches to education.
- ❑ A national consortium of educational agencies, in collaboration with professional organizations and accrediting agencies, should develop national standards for both vertical and horizontal articulation among health care training programs to facilitate student movement from one level to another within a health care discipline and from one discipline to another.
- ❑ Institutions sponsoring graduate medical education programs should affiliate with ambulatory and extended care facilities and with health care delivery networks and systems to increase physician training experiences in these settings and in managing care across different provider settings. The innovative use of such affiliations can also help solve problems related to the distribution of physicians across specialties and geographically.
- ❑ Health care providers, as major employers, should make a commitment to the educational advancement of their communities by forming coalitions with educators, employers and community leaders to address basic skill and education deficiencies in the community's manpower pool and to expand the opportunities that health professions and occupations can offer to minorities.

Efficient use of health care professionals

We also must endeavor to make better use of our human resources by enhancing career mobility within professions and eliminating barriers to the efficient use of health care professionals.

- ❑ Federal and state funding programs should provide incentives for health professions education programs to consolidate core instruction in basic science courses to conserve resources and facilitate movement from one health profession to another.
- ❑ Career ladders based on measurable and observable standards should be established for health care occupations to enable an individual to move smoothly from one level to another.
- ❑ National standards and guidelines for the evaluation of professional and occupational credentialing alternatives should be developed to distinguish credentials awarded for professional recognition or individual achievement from those needed to protect the public health and safety so that regulatory requirements can be appropriately limited to patient needs.
- ❑ Provider licensure, certification, and accreditation program standards regarding the numbers and qualifications of personnel should be revised to eliminate those elements which unnecessarily limit institutional flexibility and discretion in the use of personnel, such as cross-trained and multiskilled practitioners. Recognizing the role that institutions must play in managing their human resources, standards should focus primarily on institutional patient care outcomes and total quality improvement rather than specific staffing criteria. Such requirements should clearly reflect patient care needs and considerations, not professional ambitions or market entry limitations.
- ❑ Unnecessary and duplicative paperwork must be eliminated and remaining requirements must be revised to take full advantage of the efficiencies offered by computerized information management systems so that more personnel and personnel time are available to deliver direct patient care.

Appropriate geographic distribution

And last, but not least, we must provide the incentives necessary to attract and retain health care professionals in poor, remote, or underserved areas so that everyone has reasonable access to needed services.

- ❑ Special financial support should be directed to those educational programs which provide outreach programs in remote and other underserved areas, including expanded support to the federal Area Health Education Centers program.
- ❑ Funding should be provided to help poorer communities recruit primary care physicians, nurses, and allied health practitioners. For example, the National Health Service Corps should be expanded to increase not only the number of primary care and selected specialty physicians, but nurses, physical therapists, and other professionals in short supply in underserved areas.
- ❑ Federal regulatory barriers to the recruitment and retention of personnel, particularly in underserved areas, should be removed (e.g., taxation of scholarship and loan funds tied to future service commitments and disincentives for those over 65 to work).
- ❑ Incentives should be established for the training and use of multiskilled personnel.

A staged and orderly implementation strategy

AHA proposes step-by-step implementation of the proposal to minimize disruption in current coverage patterns and to facilitate the introduction of broader benefits. Starting with mothers and children, coverage of the poor and the near poor who are not currently covered by Medicaid should be provided by the public program over a pre-established period of time, as cost savings from the system reforms outlined above are added to other available revenues. Those able to pay their own way should be added to the public program if they are unable to obtain basic benefits coverage in the private sector.

As new benefits are added, such as outpatient prescription drugs and long term care, current public program participants, as well as new enrollees with incomes exceeding 150 percent of federal poverty guidelines, should contribute, with premiums, deductibles and copayments scaled to ability to pay. Only in the final implementation stage, and only if anticipated reform savings fall short, would increased contributions for services that now are subsidized be sought from current Medicare beneficiaries who are able to contribute.

Staged implementation also provides the opportunity to deal with major transition issues, such as the Medicare trust fund, and realigning state and local government responsibilities as the federal government assumes responsibility for the public program to provide basic benefits and catastrophic coverage.

Cost implications of the strategy

To assess the effect of this draft strategy, AHA contracted with Lewin/ICF to develop cost estimates based predominantly on their Health Benefits Simulation Model which has been used to estimate the effects of several major national health reform proposals.

Overall, there will be a \$55.9 billion increase in federal public program spending, offset by the \$4.3 billion reduction in overall private insurance spending by employers, the \$13.0 billion reduction in state and local government spending, and the \$15.6 billion reduction in direct household spending, resulting in a net national health spending increase of about 4 percent (\$23.0 billion) under the AHA plan. This is a relatively small increase in health spending when one considers the vast shortfall in access for 33 million uninsured persons and the many more who are underinsured, particularly in the area of nursing home and home health services. While utilization would increase under the AHA plan, there would be counterbalancing effects as coverage for preventive and primary care services is implemented and expenses due to delays in receiving care are avoided.

More specifically, the AHA plan will reduce health benefits costs for private employers by \$4.3 billion, the result of offsetting new spending of \$7.6 billion by employers who do not currently insure their employees and dependents with spending reductions of \$11.9 billion for employers who do currently offer insurance. Employers who now offer insurance would see their overall spending go down due to the elimination of cost-shifting and the implementation of system reforms including expanded use of managed care. In today's health care system, employers typically pay higher than average charges to cover the cost of uncompensated care provided to uninsured persons and to compensate for inadequate provider payment under government programs. The AHA plan would eliminate this cost-shifting by assuring adequate payment under the public programs and eliminating most uncompensated care through universal coverage. Although many employers will be required to insure part-time employees on a prorated basis, the elimination of cost-shifting and the implementation of cost containment features will result in an estimated net savings of \$153 per employee per year in firms that now offer insurance. The average annual premium under the AHA benefits package would be about \$1,200, at least half (\$600) of which would be paid by the employer. By comparison, the average premium in existing employer plans is about \$2,290, of which the average employer pays about 75 percent (\$1,720). The AHA plan premium cost of about \$1,200 reflects a deductible of \$500 for both inpatient and outpatient care, a \$5,000 deductible for institutional long-term care, and coinsurance of 20 percent (but none for preventive care). Among firms that do not now offer insurance, premiums for basic benefit coverage under the AHA plan would be substantially less than among most existing employer health plans due to expanded use of managed care and significant consumer cost-sharing requirements.

Federal government spending for public programs would increase by about \$55.9 billion if the program were fully implemented in 1991. However, spending by state and local governments will be reduced by about \$13.0 billion due to reductions in uncompensated care provided in public hospitals. Increased federal spending under the public program would result from providing coverage to uninsured persons who cannot afford coverage (\$9 billion), coverage of long-term care services (\$23.6 billion), prescription drug coverage for Medicare recipients (\$3.7 billion), and catastrophic coverage for all Americans (\$21.0 billion). Provider payment increases under the public program to eliminate cost shifting will be offset by cost savings from system reforms including expanded use of managed care in public programs and other offsets to Federal programs for a net decrease in government costs of \$1.4 billion.

Household spending would be reduced by about \$15.6 billion, with reductions of \$48.8 billion in out-of-pocket spending offset by an increase of \$33.2 billion in premium payments as everyone becomes covered by a basic benefits plan and everyone receives catastrophic protection.

It must be noted that the estimated effects of a proposal such as AHA's are highly sensitive to assumptions regarding changes in use rates, as well as assumptions about the offsetting savings that would be achieved through effective management of care and the other reforms described above. AHA believes the estimates provided here are relatively conservative, particularly with respect to the savings that could accrue from the package of reforms aimed at changing provider behavior and eliminating the delivery not only of unnecessary care, but care that is futile or negligibly beneficial. Currently available research provides some basis for estimating the effect on utilization when previously uninsured individuals become covered, or when previously insured individuals enter managed care programs, but there is little research that provides a sound footing for estimating the effect on medical practice patterns and the effectiveness of care management techniques when conducted in an environment supported by tort reform, clearer medical practice parameters, broader use of living wills and advance directives, and so on. Consequently, the increased costs due to utilization increases may be more fully reflected than the decreased costs due to more prudent management of care and the other system reforms included in AHA's proposal.

The most critical assumptions used in generating the estimated effects of AHA's proposal are:

- ❑ Utilization of health services by previously uninsured persons is assumed to adjust to the level reported by insured persons with similar characteristics.
- ❑ Utilization of nursing home services is assumed to increase by 25 percent.

- ❑ Utilization of home health services is assumed to increase by 100 percent.
- ❑ For illustrative purposes, the estimates assume that the program is fully implemented in 1991 and that changes in utilization and managed care savings occur immediately upon implementation of the program, even though utilization responses and managed care savings are expected in phase-in over a period of five years.
- ❑ Effective management of care and the other system reforms (e.g., tort reform) are expected to result in savings of \$29.4 billion. These estimates reflect, among other things, reduced utilization at varying rates for different populations, depending on their current form of coverage.

Everyone contributes but everyone benefits

In order for everyone to benefit from improved health care given current fiscal constraints and concerns about the efficiency of our health care system, all parties must be prepared to exercise greater economic discipline in the way they provide, use, and pay for health care services. This kind of discipline is the essence of a pluralistic system -- without more economic self-discipline, we will lose the freedom that a pluralistic system provides. AHA's proposal calls on everyone to contribute to reform, but it also provides benefits for everyone.

Consumers would be responsible for greater, but selected, cost-sharing, either paid out-of-pocket or through private supplemental coverage until catastrophic limits are reached. They may also find their choices narrowed somewhat by arrangements to manage care. In return, however, they would gain financial access to a full range of coordinated medical services, from preventive to long-term care, sharply reducing today's difficulties in obtaining needed care and the confusion that can accompany negotiating our current system. Delivery system incentives would focus on keeping them healthy, and no one would be impoverished by health care bills.

All employers would be responsible for contributing toward basic benefits coverage for their permanent employees and their dependents, but they would have much greater access to affordable health insurance. All employers would be treated equitably under tax and insurance laws. Tax incentives, hardship funds, and other subsidies would ease financial pressures of coverage. The hidden tax many businesses now pay to cover care for the uninsured and underinsured would drop dramatically as more and more corporations help underwrite insurance coverage for their employees and the government pays its health care bill in full.

Practitioners and health care facilities would be accountable for treatment outcomes on both economic and clinical grounds. Information on provider cost and quality performance and adherence to technology diffusion guidelines would be available for use by purchasers in making selective contracting decisions. Medical practice parameters would be used by third-party payers as payment screens but, more importantly, by hospitals and physicians to manage care more effectively themselves. To be eligible to contract with purchasers, providers would have to accept an appropriate share of the financial risk associated with the cost and utilization of services. Hospitals and physicians must forge effective partnerships that lead to the elimination of excess capacity, of duplicative and underused technology, and of unnecessary or ineffective care. At the same time, health care facilities would see a major reduction in uncompensated care over time, would be fairly paid for the care they deliver, and would be joined by government, purchasers, and the public in making difficult access choices when resources are inadequate to cover all services.

Private insurers would be required to change certain underwriting practices designed to avoid risk, and face competitive pressure to keep administrative costs down and premiums affordable. At the same time, they would have broader opportunities to market affordable basic benefit and supplemental insurance packages, to compete without negating the purpose of insurance through carefully constructed insurance reforms, and to administer an expanded public program.

Government would be expected to meet its obligation to ensure coverage for all those unable to do so themselves and to become a trustworthy partner in the financing and delivery of health care. At the same time, assisted through cost sharing by beneficiaries who can afford it and a more accountable health care delivery system, government would be better able to live up to its promises.

All purchasers would be expected to pay their own way without cost shifting, but all would achieve greater value for their health care dollars. They would have ready access to soundly developed medical practice protocols, guidelines on appropriate use of technology and special services, and information on the cost and quality of care delivered by specific providers.

Starting point: future plans

The American Hospital Association believes that the future lies in taking the best of the current American health care system and providing the necessary incentives to move it toward a more integrated system focused on improving the health status of all and ensuring the availability to all of affordable, quality health care services. The Association offers this strategy as a starting point to stimulate discussion and debate.

The Association seeks comments both on the overall thrust of the strategy presented and on alternative or additional specific measures that might be included in the strategy. In particular, the Association seeks comments on several controversial or unresolved issues that are central to the health care reform debate, for example:

- ☐ What incentives would work in promoting broader employment-based coverage?
- ☐ How can adverse selection be managed fairly and effectively in the private insurance market?
- ☐ What combination of federal taxes is most appropriate for funding an improved public program?

Our objective is to continue throughout 1991 to shape the *Starting Point* into a workable proposal for reform that has a broad base of support. By early 1992, the AHA Board of Trustees expects to reach closure on all major modifications and/or expansions.

Mr. WAXMAN. Thank you.
Dr. Scalettar.

STATEMENT OF RAYMOND SCALETTAR

Mr. SCALETTAR. Thank you, Mr. Chairman and members of the committee, my name is Ray Scalettar and I am a physician with a practice in internal medicine in Washington, D.C. I also am a member of the Board of Trustees of the AMA. With me today is Bruce Blehart, director of the AMA's division of Federal legislation. The AMA is pleased to have this opportunity to discuss the matter of restraining the growth of health care costs as a vital element of setting future directions in assuring all of our citizens access to essential health care.

As you know, the AMA strongly supports reforming the health care system by building on the strengths of the private/public partnership upon which our health care system is founded. In previous testimony, we presented our proposal to address the Nation's access to care problem. Today, I am pleased to focus on the issue of costs. Without question, a significant percentage of the growth in expenditures for medical and health care services reflects the circumstances in the United States where we are able to provide our patients with a breadth and quality of care that was not even imagined a few short years ago. Furthermore, our health care expenditures reflect spending for social services and medical care due to aggregate population growth, more health-conscious consumers who utilize more services and technology, inflation, and the health problems associated with increasing societal problems such as crimes, drugs and poverty.

Our health care system is costly. It continues to require more and more of our resources. The current tax structure and the health insurance system actually encourage the use of services. Furthermore, this occurs in a country where the citizens expect and most routinely receive access to the most technically advanced health care in the world. However, the AMA believes that actions can be taken to begin addressing the cost dimension of health care.

The AMA supports measures to enhance the value of every health care dollar spent. For example, the AMA is a leader in the development of practice parameters. Appropriately developed parameters will identify the medical consensus on the most effective treatment strategies for a given medical condition and will enhance the value of health care by helping to eliminate ineffective treatment and care. Where care is provided outside of a parameter, it will be appropriate for payment to be delayed, pending peer-to-peer review of the rationale for the type of treatment provided.

We support outcomes research and technology assessment to determine the effectiveness of medical treatments. An example of the cost savings and quality enhancement attributable to technology assessment is found in DATTA's evaluation of laparoscopic cholecystectomy. This type of surgery gets the patient home in less than 1 day as compared to a 5-day stay, and could reduce our national health care bill by \$1 to \$2 billion.

Essential benefits in lieu of State mandates—the AMA endorses preemption of State benefit mandates in the context of employer-

required insurance. In lieu of such mandates, employers should be required to provide a minimum, less costly, essential benefits package such as the one developed by the AMA.

Liability reform. The estimated \$20.7 billion, a conservative figure, attributable to defensive medicine and liability insurance premiums in 1989 is staggering and must be addressed. This problem also contributes significantly to the access problem by causing physicians to abandon certain procedures and areas of the country. This access problem has reached its extreme in States such as Georgia, where 57 counties have no providers of obstetric care.

Antitrust protection. We support allowing local medical societies to review and arbitrate patient complaints about fees and other matters.

Health Promotion. Society must be made aware of the severe and costly effects of inadequate shelter and lifestyle choices such as smoking, substance abuse, poor nutrition and lack of exercise. We cannot afford to overlook the value of general health education.

Administrative expenditures. All insurers, including self-insurers, should utilize a uniform claim form like HCFA 1500.

Cost-sharing. Overinsurance needs to be discouraged. Patients must be sensitized to the utilization of health resources through appropriate tax treatments, cost sharing and readily available information on fees and charges for frequently provided services and procedures.

Portability/continuity. Once covered through employment, an employee—and his or her dependents—should have the guarantee of future coverage, with no waiting period or preexisting condition limitation, at a new employer, without any rate increase due to health condition. This will lower costs due to extensive risk underwriting designed to attract only low risk individuals.

Community rating/open enrollment. Premiums charged to small business should be comparable to the per capita average across all the group insurance sold in the same community for the same benefit package. Open enrollment should be required.

Benefits/reinsurance—every insurer should be required to offer one policy with the exact required basic benefits. There should be a maximum annual cost exposure for the mandated essential benefits policy, with carriers required to participate in a reinsurance pool.

Self-insurers also should be required to help underwrite the reinsurance pool.

Mr. Chairman, in concluding my remarks, I would be remiss if I failed to convey the single most pressing issue physicians are facing today, the implementation of Medicare physician payment reform. I am sure that you realize that physicians are dismayed and angry over the misapplication of payment reform as a budget cutting tool. Just as physicians acted in good faith in 1989 when Congress enacted Medicare payment reform, we today are offering constructive ideas and directions on the issues relating to health care costs and reforming our entire method for assuring access to health care in America. However, if the payment reform matter is not properly resolved, it only stands to reason that physicians will be hesitant to accept assurances that materialize out of health care system reform.

Successful reform initiatives will require that all of the key parties work together based on a history of trust. To this end, we appreciate your efforts and the efforts of the committee.

Mr. Chairman, thank you for this opportunity to testify.

[Testimony resumes on p. 369.]

[The prepared statement of Mr. Scalettar follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION

to the
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

Presented by

Raymond Scalettar, MD

RE: HEALTH CARE SYSTEM REFORM AND COST CONTAINMENT

October 31, 1991

Mr. Chairman and Members of the Committee:

The American Medical Association (AMA) believes that every American should have access to essential health care. To fulfil this goal, the AMA strongly supports reforming the health care system, building on the strengths of the private/public partnership upon which our health care system is founded. We are pleased that we are at the point where there is general agreement that health care system reform is in our future in order to assure universal access to health care. We caution against letting endless debate stand in the way of incremental reforms that can be achieved now. We need to grasp this opportunity to address the needs of the over 30 million uninsured, and the concerns over the escalating costs of health care.

Dr. Scalettar has an active Internal Medicine practice in Washington, DC. Dr. Scalettar is a Trustee of the American Medical Association and he is accompanied by Bruce Blehart, JD, Director of the AMA's Division of Federal Legislation.

As care-givers, physicians witness the grim reality facing the uninsured. We see this population not as statistics, but as the women, men and children who seek our help at emergency departments, clinics and offices. We see the pain and illness of this population and we have put forward a comprehensive proposal to address these needs.

In previous testimony to this Subcommittee, we presented our proposal to address the nation's access to care problem. Today, I am pleased to use this opportunity to focus on the issue of costs. Before presenting recommendations from the AMA to address health care costs, these costs first need to be placed in perspective.

HEALTH CARE EXPENDITURES IN THE UNITED STATES

Total national health expenditures were \$666.2 billion in 1990 (the most recent year for which data are available), an increase of 10.5% over the \$603 billion spent in 1989. From 1985 to 1990, the rate of increase in spending for health care averaged 9.5% (Health Care Financing Administration, Office of the Actuary, Office of National Cost Estimates, 1991).

Of the total 1990 national health expenditures, 88% or \$585.3 billion was spent for personal health care expenditures, a 10.3% increase from the previous year. This growth is attributed to four factors:

- economy-wide price inflation, accounting for about 44% of the increase;
- additional health industry inflation, accounting for about 21% of the increase;
- population growth, accounting for about 9% of the increase; and
- a residual category accounting for about 26% of the increase representing all other growth factors, including new technology, aging of the population, etc.).

In the last decade, inflation has played a declining role, while volume, intensity and population factors have become more important in accounting for growth in personal health care expenditures.

Of the major medical care components, physician services is usually the slowest growing: in 1990, expenditures for physician services grew 7.1%, compared to growth of 10.9% for hospital room and 10% for prescription drugs. Over the first nine months of this year, physician services price growth dropped to an annual rate of 5.3%.

The Medicare program provides substantial information on patterns in health care spending. While total Medicare expenses continue to increase, recent data suggests that the rate of increase is slowing.*

Medicare spending increases reflect the same four categories as spending increases for all health care services, and the residual category has been the focus of increased study. According to an Urban

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- * • For Part B, the 12-month total for benefit payments for the period ending in July 1991 was \$44.5 billion, an increase of 7.9% over the 12-month period ending in July 1990. If the rate of increase for the year ending July 1990 had continued, the total payments would have been \$47 billion for the 12-month period ending in July 1991, or \$2.5 billion more than actually was paid.
- For Part A, the 12-month total for benefit payments for the period ending in July 1991 was \$68 billion, an increase of 4.1% over the 12-month period ending in July 1990. If the rate of increase for the year ending July 1990 had continued, total payments would have been \$75.8 billion for the 12-month period ending in July 1991, or \$7.8 billion more than actually was paid.
- For Parts A and B together, the 12-month total for benefit payments for the period ending in July 1991 was \$112.5 billion, an annual increase of 5.5% over the 12-month period ending in July 1990. If the rate of increase for the year ending July 1990 had continued, total payments would have been \$122.8 billion, or \$10.3 billion more than was actually paid.

Institute study, "Understanding the Recent Growth in Medicare Physician Expenditures" (funded by HCFA and published in the Journal of the American Medical Association (JAMA) on March 23, 1990), major factors behind increases in Medicare Part B expenditures between 1983 and 1985 were:

- the increase and diffusion of new medical technologies (especially in the areas of cardiology, ophthalmology, gastroenterology and urology);
- the sharp increase in the Medicare assignment rates, due to an increase of Medicare "participating" physicians; and
- the increase in the income of the elderly.

The study found technology changes and patient demand, through reduced out-of-pocket costs for Medicare beneficiaries encouraging greater use of medical services, were significant residual category factors driving up spending for health care services.

Without question, a significant percentage of the growth in expenditures for medical and health care services reflects the circumstances in the United States where physicians and other health care professionals are able to provide our citizens with a breadth and quality of care that was not even imagined a few short years ago.

It also is important to note that American health care expenditures reflect spending for social services and medical care due to problems in our society including crimes, drugs and poverty. In addition, our health care system provides services and is held accountable for expenses that are incurred in providing care that ideally is avoidable. For example:

- According to a study published in the September 18, 1991 issue of JAMA, annual hospital costs for babies born in the U.S. to cocaine-using mothers are approaching \$500 million; and

- Based on an analysis of 1985 expenses for the cost of injury in the U.S., published by the Centers for Disease Control in 1989, approximately \$5.3 billion was spent for direct medical expenses stemming from assault (\$2.4 billion) and self-inflicted injuries (\$2.9 billion).

Before turning to our recommendations regarding health care costs, it should be clearly understood that this money spent for avoidable health care needs is just the tip of societal expenses arising from factors such as drug use and violence. Demonstrated by the sales volume of tobacco products and the continued violence we inflict on one another, such expenditures unfortunately are sure to continue.

COST-EFFECTIVENESS AND COST SAVINGS

Our health care system is costly. It continues to require more and more of our resources. The current tax structure and the health insurance system actually encourage the use of services. Furthermore, this occurs in a country where the citizens expect and most routinely receive access to the most technically advanced health care in the world.

The cost of health care services is driven by many factors -- including new and improved technology, aggregate population growth, more health-conscious consumers who utilize more services and technology, inflation, and the health problems associated with increasing societal problems such as AIDS, violence and drug abuse. The AMA maintains a number of key activities that address the "cost" dimension of health care through various measures that respond to many of these factors.

- (1) Practice Parameters -- The AMA supports measures that will enhance the value of every health care dollar spent. For example, the AMA is a leader in the development of practice parameters, and is working with the nation's medical specialties

and the Agency for Health Care Policy and Research on this important issue. Appropriately developed parameters, which will identify the medical consensus on the most effective treatment strategies for a given medical condition, will enhance the value of health care by helping to eliminate ineffective treatments and care. The Joint Commission on Accreditation of Health Organizations is looking to parameters to serve as the foundation for the clinical indicators that they will be using to maintain and improve inpatient quality. Finally, where care is provided outside of a parameter it is appropriate for payment to be delayed, pending peer-to-peer review. Practice parameters will play a key role in establishing the value/quality link.

- (2) Technology Assessment and Outcomes Research* -- We support outcomes research and technology assessment to determine the effectiveness of medical treatments. The AMA devotes significant resources to technology assessment through its Diagnostic and Therapeutic Technology Assessment (DATTA) program. Since 1982, DATTA has been evaluating the safety and effectiveness of drugs,

* An example of the cost savings and quality enhancement attributable to technology assessment is found in DATTA's evaluation of Laparoscopic Cholecystectomy, a new method to remove a diseased gallbladder. This type of surgery gets the patient home in less than one day as compared to a 5-day study for a conventional cholecystectomy. Also people are returning to work 3 days after surgery compared to a 4-6 week convalescence with an open cholecystectomy. This new surgery could significantly reduce our national health care bill by an estimated annual savings of \$1-2 billion, and having the further positive effect of quickly returning workers back to their jobs.

devices, procedures and techniques used in the practice of medicine. DATTA draws from a panel of 2,500 expert physicians who evaluate new and emerging technologies. The results of these assessments are communicated to practicing physicians and more than 1,150 health care organizations, primarily through AMA publications.

- (3) Essential Benefits in Lieu of State Mandates -- The AMA endorses preemption of state benefit mandates in the context of employer-required insurance. The list of required coverage varies from state to state. For example, Hawaii and Idaho require coverage for three types of providers in addition to physicians and hospitals, and Maryland and California require coverage for thirteen such providers. In lieu of such mandates, which often require very expansive packages, employers should be required to provide a minimum, less costly, essential benefits package such as the one the AMA has developed. A broader package certainly could be provided at the employer's³ option or upon employee/employer agreement.
- (4) Liability Reform^{*} -- The AMA supports federal reform of the medical liability system. The estimated \$20.7 billion, a

* The AMA supports the following federal reforms: offset of collateral source benefits; a cap on non-economic damages of \$250,000 or less; periodic payment of future damages; tolling the statute of limitations for minors for no more than six years from birth; and establishing a decreasing sliding scale for attorney contingent fee regulation. We also support minimum expert witness criteria, requiring that a certificate of merit be filed as a condition to filing a liability suit and demonstration of fault-based administrative dispute resolution systems such as the one we developed in conjunction with medical specialty societies.

conservative figure, attributable to defensive medicine and liability insurance premiums in 1989 is staggering. These costs contribute significantly to the access problem by causing physicians to abandon certain procedures and areas of the country. In 1987, former Health and Human Services Secretary Bowen's task force on liability reported decreased access attributable to liability in 26 states, with obstetrical and gynecological services the most likely to be affected, and low-income individuals the most likely to be deprived. This access problem has reached its extreme in states such as Georgia, where 57 counties have no providers of obstetric care.

- (5) Antitrust Protection -- The AMA supports allowing local medical societies to review and arbitrate patient complaints about fees and other matters. Under present Federal Trade Commission (FTC) interpretation [Iowa Dental Association, 99 FTC 648 (April 9, 1982)], effective fee peer review is unlikely given the fact that the FTC safe-harbor for this activity is limited to situations where: participation is voluntary for both the physician and the patient; the medical society opinion is non-binding; and there is no public discussion of the propriety of the physician's fee. Amendment of federal antitrust laws is needed to allow local medical societies to conduct reviews of excessive fees without the fear of antitrust liability.
- (6) Health Promotion -- The AMA supports health promotion and preventive health measures such as S. 891, the Cancer Screening Incentive Act of 1991. Society must be made aware of the severe

and costly effects of inadequate shelter and lifestyle choices such as smoking, substance abuse, poor nutrition and lack of exercise. We cannot afford to overlook the value of general health education and the need for continued promotion of family values. The AMA strongly supports and lobbies for health effects advertising, effective hand gun control and restrictions on tobacco and alcohol promotion.

- (7) Administrative Expenditures -- All insurers, including self-insurers, should utilize a uniform claim form such as the one developed by the Uniform Claim Form Task Force (chaired by the AMA) and used by the Medicare program as HCFA form 1500. There also should be a standardized format for electronic claims.
- (8) Cost-sharing -- Over-insurance needs to be discouraged. The AMA believes that patients must be sensitized to the utilization of health resources through appropriate cost-sharing and readily available information on fees and charges for frequently provided services and procedures. To aid consumers in meeting personal health care expenses, they should have the option of spending funds deposited in a flexible benefit account (an IRA for health care purposes). There also should be a limit on the favorable tax treatment of employer-provided coverage. The Congressional Budget Office estimated in 1989 that taxing employer contributions that exceed \$250 a month for family coverage and \$100 a month for individual coverage would "raise revenues by about \$40 billion and payroll tax revenues by about \$21 billion over the 1990 - 1994 period." An average of \$12

billion per year over five years would go far to meet the needs of the uninsured.

- (9) Portability/Continuity -- Once covered through employment, an employee (and dependants) who leaves that employment should have the guarantee of future coverage, with no waiting period or pre-existing condition limitation, at a new employer without any rate increase (other than due to geographic location) to the employer or employee due to health condition. (This will lower costs due to extensive risk underwriting designed to attract only low risk individuals.)
- (10) Community Rating/Open Enrollment -- Premiums charged to small business should be comparable (no more than 10% higher) to the per capita average across all the group insurance sold in the same community for the same benefit package during the preceding three months. Open enrollment should be required.
- (11) Benefits/Reinsurance -- Every insurer should be required to offer one policy with the exact required basic benefits (no more, no less), with payments for care and services based on three options: a benefit payment schedule, a service benefit version (where reimbursement probably would be based on a UCR model), and a pre-paid version. (The offering of additional policies should be encouraged.) There should be a maximum annual cost exposure of (\$25,000) for the mandated essential benefits policy, with carriers required to participate in a reinsurance pool. Self-insurers also should be required to help underwrite the reinsurance pool.

CONCLUSION

The growth in expenditures for medical and health care services reflects the reality in the United States where physicians and other health care professionals and providers are able to provide our citizens with a breadth and quality of care that was not even imagined a few short years ago. Meeting this need has resulted in the U.S. clearly being recognized as the leader in the development of health care technologies and services and to our citizens being more productive in their daily activities.

In conclusion, we recognize that cost containment initiatives need to be nurtured now if we are to have reasonable expectations that health care reform actions of the future are to succeed. However, difficulty in reducing the growth of costs needs to be recognized. While the AMA fully supports efforts to root out spending for unnecessary services, efforts to accomplish this goal should not be made at the expense of patients.

Mr. Chairman, thank you for the opportunity to testify. I will respond to questions at the appropriate time.

Mr. WAXMAN. Thank you very much for your testimony. Mr. Pollack, in my bill I suggested making payment rates established for the new public program available to private employers. You testified that this approach would lock in inadequate payment rates.

We all understand this approach is part of a larger plan to provide payments for millions of patients that hospitals now serving without any payment. If you assume that payment rates for the new public plan would be set at a reasonable and adequate level, as I do for all patients, would you then support the plan?

Mr. POLLACK. Our problem is you, Mr. Chairman, have been very helpful in leading efforts for adequacy and reasonableness of rates, but unfortunately our experience in dealing with the process as a whole since 1983 on the Medicare side has been woefully inadequate and basically as Stewart Altman testified earlier today, under government rates we are at 91 percent of cost.

You know the story on Medicaid. If that were applied to everything we would be in a very difficult situation.

Mr. WAXMAN. My question is if you are getting paid at Medicare rates as opposed to Medicaid rates which reclaimed to be 90 percent and then you got covered for those people that you see for whom you get no compensation, doesn't it come out about right?

Mr. POLLACK. I am not so sure it does. First of all, as long as those rates are set to the Federal budget process and as long as they are susceptible to becoming ratcheted down through a process that has no relationship to the way the rates ought to be set, there are an awful lot of concerns.

The second thing is we are dealing in sort of the box of regulating the separate rate, rather than talking about changing the whole delivery system in a way that makes more sense. And you know we really think that we need to look more globally in the way we do things and move into different arrangements where we get to managing care for people.

You know our proposal tries to move in that direction, but the bottom line, Mr. Chairman, is, given our experience, it is hard for us to believe that they would be reasonable and adequate given the history.

Mr. WAXMAN. Well, Dr. Scalettar himself a minute ago referred to recent history with the physician community with the government setting rates. I accept as what you have to say as a serious criticism. Over 290 members of the House have sent that same message to this administration that we are very dissatisfied with the way they treated the physician reimbursement under the new reform.

I particularly am resentful of their conduct because I know the physician community works so hard to accomplish the RBRBS reform to which we look to with the idea that there would be rationality brought into the whole reimbursement system. To undermine the success of that effort before it even gets started, to me, is a very serious mistake on the part of this administration.

Mr. SCALLETAR. I want to thank you, Mr. Chairman, for all your help. It is a serious problem and it does undermine the confidence of any type of payment mechanism that might be coming forth in the future.

Mr. WAXMAN. Chairman Roth put forth a recommendation for annual limits and increased—we propose public plan payment rates be available to private plans. Would the AMA support any of these approaches?

If not, are there any cost containment proposals supported by the AMA that would give us some assurance that health costs would not increase at current rates?

Mr. SCALLETAR. I think this is one reason we have gone to the RBRBS approach rather than the historical payment mechanisms which were so inflationary and difficulties started in many ways. I think the physicians would find it very difficult to have a payment plan that is ratcheted down on an absolute basis. I think it flies in the face of reality that so many physicians are required to give a lot more care and it would diminish initiative, incentive.

I think it would be very difficult to accept a rigid plan that does not take into account the individual variations of every patient and the type of problems that we are dealing with.

Mr. WAXMAN. Well, you cite the RBRVS system. Do you think RBRVS ought to be available for all payers?

Mr. SCALLETAR. I suspect we will see it utilized in this way. I think it will be phased in. I am sure the insurance industry is going to be looking at it and probably will start utilizing this. I think this is clearly the message the health insurance industry has sent.

Mr. WAXMAN. We end up finally phasing in a resource-based value system, and then take the physician fee schedule based on that system and allow certain increase per year, perhaps relative to growth and inflation rate and the economy, wouldn't that—but not too limited just to that—wouldn't that be a reasonable way to decide what increases there ought to be year after year?

Mr. SCALLETAR. I think we have to certainly take into consideration inflation and so many other factors, liability and all the other resources that go into it, but, again, I don't think we can except a payment schedule as payment-in-full, because it just does not allow one to be compensated for the effort that one gives on an individual case basis.

Mr. WAXMAN. Well, if you have an individual case and there is sort of a resource-based value for that service and you start off with what the existing reimbursement is for that service, you are taking into consideration the individual factors that go into the physician service itself such as the relative value of that service to others, the education prepared for that service and so on and so forth.

If you use that as the base and then looked at the realities of increases in the inflation, increases in malpractice insurance, if it is out of line with increasing it at the same rate as other costs in the economy, why wouldn't that be individually enough sensitive?

Mr. SCALLETAR. Because it still does not allow for the individual effort—it is the same thing in Medicare which is balanced billing in terms of when—for example, if one is a participating physician, you are locked into accepting what is paid plus the 20 percent co-payment.

Mr. WAXMAN. What is important? Is it important to get your fee or important to have the ability to get more than your fee from a patient that you think can pay more?

Mr. SCALLETAR. In the first place.

Mr. WAXMAN. Isn't the value of being able—isn't the argument for going against the patient for more money based on the fact that Medicare doesn't pay an adequate fee but if Medicare paid the adequate fee, wouldn't that be good enough?

Mr. SCALLETAR. We have already seen historically how this is playing out with the conversion factor fee. We are finding ourselves going to accept a very inadequate fee.

You know, physicians want to give care and they want to have access to care. Even the entire subject of focusing on the reimbursement is bothersome. The fact of the matter is we have to pay our rent and pay our premiums and pay our staffers and pay their health insurance. Unless we are able to have a reasonable schedule and charge for what is frequently additional effort that is expected and required and necessary, I am very pessimistic that all these reimbursement mechanisms will just be ratcheted down year after year. Perhaps would you tell us accepting—perhaps increases in inflation.

Mr. WAXMAN. Well, I appreciate the testimony that both of you have given. We will look forward to continuing our discussions about these issues.

Thank you very much. That concludes our hearing for the day.

[Whereupon, at 2:35 p.m., the subcommittee was adjourned.]

[The following material was submitted for the record:]

STATEMENT

of the

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) appreciates the opportunity to comment on the issue of health insurance coverage and health care costs. As the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), which is 96 percent of all nurse anesthetists who practice across the United States, AANA wants to convey our strong commitment to improving the nation's health care system. We commend the Committee for its leadership in structuring this critical debate on health care reform.

The AANA believes that reform of the current health care system is necessary because as many as 37 million Americans do not have adequate health care coverage. For that reason, the AANA is one of the 45 national organizations that have endorsed **Nursing's Agenda for Health Care Reform**, which calls for building a new foundation for health care in America while preserving the best elements of the existing system.

We firmly believe that every American should have access to quality, cost-effective health services, including anesthesia services. The AANA is proud of the fact that CRNAs currently provide access to quality, cost-effective anesthesia, particularly in rural areas. However, the ability of CRNAs to continue to contribute to affordable health care solutions, can only occur when marketplace competition allows them to work without unnecessary practice constraints.

ACCESS

- CRNAs personally provide more than 65 percent of all anesthetics administered in the United States annually, according to a 1988 Center for Health Economics Research (CHER) study.

- CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capability.

COST-EFFECTIVENESS

- There is mandated coverage and payment for CRNA services under the federal Medicare program and the Civilian Health and Medical Program of the Uniformed Services. In addition, under the Federal Employees Health Benefits program, claims for services provided by CRNAs receive the same consideration as claims for services provided by anesthesiologists. At present, 30 states require direct Medicaid reimbursement to CRNAs. Currently, approximately 12 states have mandated coverage and payment for CRNA services by private insurance plans. In addition, many private insurers in the remaining states voluntarily cover and provide payment for CRNA services. The AANA believes that mandating coverage and payment for CRNA services does not increase overall health care costs because anesthesia services are currently covered services under

all of the above programs.

- CRNAs have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries; only approximately 30 percent of anesthesiologists are participating physicians.

MARKETPLACE COMPETITION

The AANA believes that consumers should have freedom of choice regarding which health care provider performs a service for them. In several states, there have been cases of physician-controlled or physician-influenced insurance companies attempting to restrict the provision of anesthesia by CRNAs. Insurance companies accomplish this by not voluntarily covering CRNA services, by adopting restrictive requirements regarding supervision of CRNAs, or by raising premiums for surgeons or obstetricians working with CRNAs. These types of practices by physician-controlled or physician-influenced insurance companies often raise serious antitrust issues. Some of these non-coverage decisions or restrictions have been adopted out of ignorance of the quality of care rendered by CRNAs. In other cases, non-coverage decisions or restrictions may have been adopted at the urging of anesthesiologists. This occurs most of the time when anesthesiologists serve on the board of directors of these insurance companies.

Marketplace competition demands that all health care providers be given the opportunity to provide services that they are legally qualified to provide. Enhanced competition can result in decreased costs to the consumer.

QUALITY OF CARE

- CRNAs have administered anesthesia for over a century. All existing data, including the 1988 CHER study, demonstrate that there is no difference in anesthesia outcomes based on whether the provider is a CRNA or an anesthesiologist. There is no data to support the claim that anesthesia care provided by an anesthesiologist is of higher quality.

- CRNAs working alone are involved in 97 percent of all types of cases regardless of procedural complexity. For example, four CRNAs in solo practice are involved in open heart surgery at Sacred Heart Medical Center in Spokane, Washington.

- The Centers for Disease Control recently decided not to conduct a national study on anesthesia morbidity and mortality because anesthesia morbidity and mortality rates are so low that it was felt that a national study was not justified.

RECOMMENDATIONS

The AANA urges Congress to adopt a legislative solution to the current health care crisis that will allow Americans to have access to quality, cost-effective health care, including anesthesia services provided by CRNAs. Such legislation should incorporate the following general concepts:

1. Consumers should have freedom of choice regarding the licensed health care practitioner who will provide their care.
2. Federal payment for a health service should not be different based on the type of licensed health care practitioner providing the care.
3. There should be deference to State law, regulations and legal decisions regarding practice requirements for health care practitioners.

CONCLUSION

The AANA looks forward to working with the Committee to enact the necessary reforms in the health care system that will allow Americans to have access to quality, cost-effective health care, including anesthesia services. Thank you for giving consideration to our views on this issue.

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